Hannah's Helping Hands P.O. Box 954 • Collinsville, OK 74021 • 918-697-LOVE (5683) • hannahshelpinghands@yahoo.com

Consent for Release of Protected Health Information

This form MUST accompany the Application for Charitable Assistance from Hannah's Helping Hands Inc .

PARENT/GUARDIAN RELEASE

I,_____

_____
Name of Patient

Authorize the physicians and staff of the facility or medical practice treating this patient to release to:

☐ Patient ☐ Parent ☐ Guardian legal custody of:

SSN:____-____-____ DOB: ____/____/____

Hannah's Helping Hands , Inc
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All the following medical information regarding this patient:

- ☐ Lab Reports
- ☐ Billing Records
- ☐ Radiology Reports
- ☐ Medical List/Invoice
- ☐ Reports of Treatment/Diagnosis
- ☐ Medications/Prescriptions
- ☐ The following other information or documents

_____

Treatment dates to be included in disclosure:

____/____/____ to ____/____/____

Method by which information is to be released:

- ☐ Mail
- ☐ Fax
- ☐ Verbal Exchange
- ☐ Other:_____

_____

Information is being released for the following purpose: To qualify for charitable assistance from **Hannah's Helping Hands, Inc.** a non-profit organization.
This Consent expires one year from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release. I also understand that I may revoke this consent in writing at any time unless action is already been taken based upon it. I freely and voluntarily give this consent.

This authorization allows the physicians and staff of the facility or medical practice to communicate regarding the patients treatment with the staff and volunteers of Hannah's Helping Hands, Inc..

I understand that the information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer protected by federal law.

THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DESEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS AN ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

_____ _____ _____ _____
Signature of consumer, parent, guardian of | Date | Witness (Optional) | Date

PHYSICIAN CERTIFICATION I certify that the patient in this application is **currently receiving treatment** from the following facility or medical practice:

_____ for a form of cancer.
Name of facility or medical practice

_____ _____ _____
Physician | **Date** | **Social Worker**