HIPAA FORM

Authorization for Use/Disclosure of Protected Health Information

TO: _____
(Physician)

_____
(Physician's Address)

_____
(Physician's Telephone Number)

RE: _____
(Patient – Print Name Legibly)

_____
(Patient's Date of Birth)

I authorize the use and disclosure to the Dreams of Joy Foundation of protected health information about the Patient as described below:

Information that may be used/disclosed: All protected health information relating to Physician's assessments of:

(a) whether Patient is medically eligible for the Dreams of Joy Foundation services; and
(b) if so, whether his/her desired wish is medically appropriate. In addition, Physician is authorized to fill out, sign and provide to the Dreams of Joy Foundation forms that the Dreams of Joy Foundation may require, including forms relating to Patient's medical eligibility, the requested wish and medical considerations relating thereto.

Persons authorized to use/disclose the information: The Physician identified above, as well as his/her authorized representatives.

Persons authorized to receive the information: Employees or other authorized representatives of:

DREAMS OF JOY FOUNDATION
9006 Brixworth Court * Old Hickory, TN 37138
615-679-8001 (phone) DreamsofJoyFoundation@gmail.com (email) DreamsofJoy.org

Purpose for which information will be used/disclosed: To enable the Dreams of Joy Foundation to obtain:

(a) physician's assessments regarding whether Patient is medically eligible to have a wish granted by the Dreams of Joy Foundation and, if so, whether the requested wish is medically appropriate; and
(b) pertinent information relating thereto.

Expiration date/event:
This authorization expires once Patient's wish has been granted by Dreams of Joy Foundation or a final determination has been made that Patient is not eligible to receive a wish.

Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge the following:

(a) I understand that I may revoke this authorization at any time by so notifying Physician in writing, except to the extent that action has already been taken in reliance on the authorization; (b) I understand that if the person/entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations, such information will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Patient Name	Patient Signature	Date
Patient Representative	Patient Representative Signature	Date