Application for Family Support

Visit our website at www.hugsofhope.org for updated information.

Patient's name____ Date of Birth ____________________

Parents' Name(s) _____________________________ Who does child live with?______________

Family Address____ Zip_____________

Phone #s_____________________________________ Email _____________________________

Siblings (names/birthdates)____

____

What school(s) do your children attend?____

Diagnosis____

Date of diagnosis_______________________ Treatment Center_________________________________

Oncologist___________________________ Pediatrician_________________________________

Present Health/Treatment phase____

Oncologist's signature and date____

Do you have a caringbridge/care page site? ____

Can we share website info/photos of your child on our website or FB page?____________________

What are some of your child's hobbies/interests? ______________________________________

With my signature, I agree that the information provided to the Hugs of HOPE, Inc. is true and accurate. I authorize the foundation to use photos of my child and our family (unless noted above). I am also willing to share photos and information in order to help the foundation fulfill its mission to raise awareness and provide support for pediatric cancer to other local families. Funds received from Hugs of Hope will be not misused or requested with false intent. Funds requests and communications must be made by parents or legal guardians. We request parents/guardians attend functions with their child(ren) as often as possible to benefit from additional resources.

Parent/Guardian Signature____Date___________________

- 3824 Skipper Bridge Rd Valdosta.GA 31605 *229.561.0840
- www.hugsofhope.org*mepitts@hugsofhope.org

HIPPA Privacy Authorization Form

Child's Name ____

**Authorization for Use or Disclosure of Protected Health Information

(required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize ____ (oncologist) to use and disclose the protected health information described below to **Hugs of Hope, Inc.**

2. Effective Period

This authorization for release of information covers the period of healthcare from (choose one)

a. __________________(diagnosis date) to ____________________ (one year from now)

OR

b. All past, present, and future periods.

3. Extent of Authorization

a. I authorize the release of _______________________ (name of patient) complete health records in relation to pediatric oncology treatment, therapy related to treatment, including records related to mental healthcare).

OR

b. I authorize the release of ______________________ (name of patient) complete medical health record with the exception of the following information:
   a. Mental health
   b. Other: Please specify_________________________________

4. This medical information may be used by the person (Hugs of Hope, Inc) I authorize to receive this information for medical treatment or consultation, billing or claims payment, financial assistance requests or for other purposes as I may direct.

5. This authorization shall be in force and effective until _________________________(date or event), at which time this authorization will expire. (expected end of treatment or date at least one year in future should be used-whichever is sooner or preferred).

Child's Name____

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my child's treatment, payment, enrollment, or eligibility for benefits from the medical provider will not be conditioned on whether I sign this authorization.

8. I understand this information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of patient or personal representative

____

Printed name of patient or personal representative and relationship to patient

____

Date