961 Hillwind Road
Minneapolis, MN 55432
Office :(763)502-1500
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www.wishesandmore.org

Authorization For Use/Disclosure Of Protected Health Information

TO: _____ **("Physician")**

_____

_____ _____**Physician's phone**

(Physician's name and address)

RE: _____ **("Patient") DOB** _____

I authorize the use and disclosure to ***Wishes & More***® of protected health information about 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 ***Wishes & More***® 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 ***Wishes & More***® any forms that ***Wishes & More***® 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:** Authorized representatives of ***Wishes & More***® 961 Hillwind Road, Fridley, MN 55432, office 763-502-1500 or fax 763-502-4707.
- **Purpose for which information will be used/disclosed:** To enable ***Wishes & More***® to obtain: (a) Physician's assessments regarding whether Patient is medically eligible to have a wish granted by ***Wishes & More***® 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 ***Wishes & More***® or a final determination has been made that Patient is not medically eligible to receive a wish.

Statements required by HIPAA: In accordance with the Health Insurance Portability and Accountability Act, I acknowledge: (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 I may refuse to sign this authorization and that my refusal to do so will not affect Patient's ability to obtain treatment or payment or eligibility for benefits; and (c) 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.

_____

(Name of Patient's representative)

_____

(Relationship to Patient)

Date: _____ _____

(Signature of Patient's representative)

***Wishes & More** enhances the life of a child fighting a terminal or life-threatening condition by providing extraordinary experiences … and more.*