HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

I, _____, hereby authorize _____ and its affiliates, its employees and agents (collectively _____), to release to House of Hope my personal health information maintained by _____ (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of investigating and evaluating my qualifications to participate in the House of Hope Sober Living Residence Program. I understand that any personal health information or other information released to the House of Hope may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire _____ [**INSERT DATE UPON WHICH THIS AUTHORIZATION EXPIRES**].

I understand that I have a right to revoke this authorization by providing written notice to House of Hope. However, this authorization may not be revoked if House of Hope, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Name of Participant _____

Signature: _____

Date: _____

If applicable, Legal Representative sign below:
By signing this form, I represent that I am the legal representative of the Participant identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Participant's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date:_____

Name of Witness: _____

Signature of Witness: _____