This letter should be shared with the healthcare professional or organization providing care to your child. It will allow LJ’s Healing Hearts to validate information included in your application for assistance.

Dear Healthcare Provider,

**Authorized Designee for Release of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as an applicant for assistance through LJ’s Healing Hearts, an Illinois not-for-profit corporation with its principal offices at 820 Delacourte Avenue in Bolingbrook, Illinois (60490), hereby authorize the following designated representatives of LJ’s Healing Hearts, or any designated representative named by such corporation for the limited purpose of carrying out the responsibilities of determining whether I, my successors or assigns qualify for benefits, donations or other assistance provided by, on behalf of or in relation to my application for assistance through LJ’s Healing Hearts, regardless of whether I am selected as a recipient of benefits, donations or other assistance, to act as my agents with respect to the matters specified in this Release:

Betsy Shannon  
Secretary   
LJ’s Healing Hearts   
820 Delacourte Avenue  
Bolingbrook, Illinois 60490

**Authorization for Release of Protected Information**

I hereby authorize any doctor, physician, medical specialist, psychiatrist, chiropractor, health-care professional, dentist, optometrist, health plan, hospital, hospice, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, pathologist, or other provider of medical or mental health care, as well as any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has paid for or is seeking payment from me for such services (referred to herein as a "covered entity"), to give, disclose, and release to my agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually-transmitted diseases, mental illness, and drug or alcohol abuse. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to any protected medical information, pertaining to myself or my child, to my agent.

The authority given to my agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to my agent may be subject to redisclosure by my agent and may no longer be protected by HIPAA.

This Release and all of the provisions contained herein are effective immediately. I intend for my agent to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information, the same of my child and other related medical records. This Release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C.A. § 1320d, and 45 C.F.R. § 160.101 et seq.

This Release shall terminate on the first to occur of: (1) two years following my death, or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, electronic mail, or any other receipt evidencing actual receipt by the covered entity. This Release shall not be affected by my subsequent disability or incapacity. There are no exceptions to my right to revoke this Release.

Further, I hereby release each covered entity, as defined by HIPAA, that acts in reliance on this Release from any and all liability, which may result from my disclosing my individually identifiable health information, that of my child or spouse, and other medical records for the purpose of applying for assistance through LJ’s Healing Hearts.

I authorize my agent or their designee to bring a legal action against a covered entity, which refuses to accept and recognize this Release. No covered entity may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR 164.508(b)(4) applies.

Further, in order to fulfill my intent as expressed herein, I authorize my agent or their designee to sign any documentation that my agent deems necessary or appropriate in order to secure the disclosure of my individually identifiable health information and other medical records.

Any information disclosed to my agent or their designee pursuant to this Release may subsequently be disclosed to another party by my agent. My agent shall not be required to indemnify a covered entity or perform any act in the event information is subsequently disclosed by my agent.

As stated above, I hereby authorize and agree to the terms of this release of protected information, as set forth above, on this \_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2016, in the County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, State of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(Print)

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Address

**Witnessed by:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

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Name(Print)

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Address