AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Infant Name: _____ Expected Date of Birth: _____
Social Security No.: _____
Address: _____
City: _____ State: _____ Zip: _____

I authorize any hospital, physician, psychiatrist, psychologist, counselor or medical provider and/or any other entity that has medical information to disclose the above-named individual's health information to HEART OF ADOPTIONS, INC., as described below.

The type and amount of information to be disclosed is as follows:
All Biographical and Medical Information and Reports; Prenatal Medical Record; Physical Examination Reports; Laboratory Reports; Immunizations; X-ray Reports; Medical Data for WIC Certification; HIV Test Results; Alcohol and Drug Screening; Psychological Testing; Psychiatric, psychological or any other mental health records including all counseling records and reports. This includes past, current and future records.

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral or treatment for alcohol and drug abuse (as permitted by 42 CFR part 2) and specifically includes the results of any drug, blood alcohol, HIV, and psychological tests.

This information may be disclosed to and used by the following person or organization:

Attorneys for adoptive parents; Adoptive Parents; Attorneys for adoption agency;
Agency for adoptive parents; Court in connection with adoption, as necessary; or
Interstate Compact on the Placement of Children, as necessary.

This authorization contemplates the sharing of information that might otherwise be protected and is intended to constitute a release of confidential and privileged information and communication.

This disclosure and use is for the following purpose: Adoption matter.

I also authorize the release of the child's birth certificate from Vital Statistics.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from the signature date.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. A photostatic copy of this authorization shall serve in its stead.

_____ _____
Witness Signature of Individual

Date: _____