Rare Kids Network ℠

PARENT AND/OR LEGAL GUARDIAN AUTHORIZATION

I, _____ (***parent and/or legal guardian's name***) hereby authorize Rare Kids Network ("RKN"), through its employees or agents, to contact the physicians listed below to request, obtain, review, and/or discuss information relating to the diagnosis, treatment, and/or condition of

_____ (***child's name***).

PHYSICIAN	TELEPHONE NUMBER
_____	_____
_____	_____
_____	_____
_____	_____

This authorization shall terminate upon the earliest of the following to occur: (i) the termination of my child's participation with RKN or (ii) my revocation of this authorization. I understand that I may refuse to sign this authorization. I understand that RKN will not condition my child's participation with RKN on my decision as to whether to provide this authorization, nor would my refusal to sign this authorization affect any payment, enrollment or eligibility for benefits from any source. I may revoke this authorization at any time by providing written notice of my intent to revoke this authorization to RKN at:

Rare Kids Network
5501 Merchants View Square, #747
Haymarket, Virginia 20169
Attn: Intake Coordinator

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I understand this authorization cannot be revoked to the extent that action has already been taken in reliance on this authorization prior to the date RKN receives my written request to revoke authorization.

RKN will not request, obtain, review or discuss personal health information beyond the scope of this authorization without my written consent or authorization. I understand that disclosed information may be subject to redisclosure by the recipient, and may no longer be considered to be protected health information pursuant to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

_____

Signature of Parent and/or Legal Guardian

_____

Print Name

_____

Date

_____

Relationship