Rare Kids Network ℠

PARTICIPANT AUTHORIZATION

I, _____ ***(name)*** hereby authorize Rare Kids Network ("the Company") acting through its employees or agents, to use and/or disclose protected health information for the following purpose(s):

_____

_____

_____

_____

_____

Such use or disclosure may be made to one or all of the following persons or entities (the "Recipient"): _____

Information to be disclosed (check all that apply):

☐ **Face Sheet**	☐ **Laboratory Reports**	☐ **Progress Notes**	☐ **Entire Chart**
☐ **History & Physical**	☐ **X-ray Reports**	☐ **Physicians' Orders**	☐ **Detail Billing**
☐ **X-ray Films**	☐ **Nurses' Notes**	☐ **Pathology**	☐ **Consultations**
☐ **Ultrasound Images**		☐ **Ultrasound Reports**	

☐ **Other (please describe):** _____

This authorization shall terminate upon the earliest of the following to occur: (i) the termination of my association with either the Company or the Recipient; (ii) the termination of

the affiliation between the Company and the Recipient; or (iii) my revocation of this authorization.

I understand that I may refuse to sign this authorization. I understand that the Company will not condition my child's participation with the Company 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 further understand that I may revoke this authorization at any time by providing written notice of my intent to revoke this authorization to the Company at:

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

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 the Company receives my written request to revoke authorization.

The Company will not use or disclose 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 Participant or Participant's Legal Representative

_____
Print Name

_____
Date

_____
Relationship (if signed by person other than participant)