Authorization for Release of
Protected Health Information

I, the undersigned, hereby authorize the release of the Protected Health Information identified below by ____ (the "Provider") to:

(Physician/Hospital Name)

Show Me A Cure's Helping Hand
P.O. Box 2283
Florissant, MO 63032-2283

The Protected Health Information from my medical records and/or x-rays to be released is to be limited to: (Please specify date of visit, test, or injury). If full release of all information in your medical record is authorized, specify "No limitations."

____________________________________ ____________________________________

____________________________________ ____________________________________

I understand that this request does not apply to: (1) certain health information that is not held in the Provider's designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right to access under HIPAA.

I understand that the purpose for which this information is to be released is for investigation of my application for financial assistance from Show Me A Cure's Helping Hand program.

I understand that Show Me A Cure is not required to comply with the federal privacy protection regulations, and such information disclosed to Show Me A Cure may be re-disclosed by Show Me a Cure.

I understand that I may revoke this authorization at any time by delivering a written revocation to the Provider, and if I revoke this authorization, it will have no effect on actions already taken in reliance on this authorization.

The Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

____________________________________ ______________________________

(Signature of Patient/Personal Representative) (Date)

_______________________________	_______________________________
(Printed Name of Patient)	(Date of Birth)
_______________________________	_______________________________
(Patient Address)	(City, State, Zip)
_______________________________	_______________________________
(Printed Name of Personal Representative)	(Capacity to Act for Patient)

____

(Address and Telephone Number of Personal Representative)

This Authorization for Release of Protected Health Information is void 90 days after the date of its execution unless expressly revoked at an earlier time.