

**HELPING OTHER PEOPLE'S ENRICHMENT, Inc. ("HOPE")**

**3063 George Washington Memorial Highway, Hayes, VA 23072**

**Phone: 804-684-2555; Fax: 804-642-6722**

**PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION**

**Section A (Must be Completed In Full for All Authorizations)**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations.

**Patient Name:** \_\_\_\_\_ **ID#** \_\_\_\_\_

Persons/Organizations Providing My Information

Persons/Organizations Receiving My Information

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

**Helping Other People's Enrichment (HOPE)**  
**PO Box 752**  
**Hayes, VA. 23072**

Specific Description of My Information and Dates of Service To Be Released:

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

**Section B (Completed Only If A Health Plan Or A Health Care Provider Has Req. The Authorization.)**

**The health plan or health care provider must complete the following:**

What is the purpose of the use or disclosure? \_\_\_\_\_

Will the health or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? [ ] YES [ ] NO

**The patient or the patient's representatives must read and initial the following statements:**

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. **Initials:** \_\_\_\_\_

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initials:** \_\_\_\_\_

**Section C (Must be Completed In Full for All Authorizations)**

**The patient or patient representative must read and initial the following statements:**

I understand that this authorization will expire on \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YR) **Initials:** \_\_\_\_\_

I understand that I may revoke this authorization at any time by notifying HOPE, Inc. in writing and if I do revoke it, it won't have any affect on any actions they took before they received the revocation. **Initials:** \_\_\_\_\_

\_\_\_\_\_  
Printed Name of Patient or Patient Representative

\_\_\_\_\_  
Relationship to Patient (Brother, Sister or Self)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date