Medical Information Release Form
(HIPAA Authorization)

Patient: _____ Date of Birth: _____

Partner: _____ Date of Birth: _____

Release of Information

By signing below, I authorize the following medical provider to disclose certain protected health information about me (or my Partner, if applicable) to Parental Hope, Inc. for the purpose of applying for the Parental Hope Family Grant.

Name of Medical Provider:_____

Address:_____

Physican:_____

This Release of Information will remain in effect until terminated by me in writing.

Signature of Patient:_____ Date: _____

Signature of Partner:_____ Date:_____

Witness:_____ Date:_____