340 West B Street, Suite 101
Casper, WY 82601
Office: (307) 235-3421
Fax: (307) 265-4668

Authorization to Release Information

This form is used to release your child's protected health information as required by federal and state laws. Your authorization allows your child's doctor and hospital to release your child's protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to your child's doctor and hospital. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Name of Child: _____DOB: _____
Address: _____
_____ Phone: ( ) _____

As Parent/Guardian of (child's name) _____, I authorize

(doctor's name)_____
(address) _____

AND

(hospital's name) _____
(address) _____

to release my child's protected health information to JASON'S FRIENDS FOUNDATION, 340 West B Street, Suite 101, Casper, WY 82601.

The information to be released consists of the **diagnosis, schedule and course of treatment** in order to determine eligibility and the extent of support to be received in the Jason's Friends Foundation program.

This authorization will expire when I revoke this authorization by notifying both the doctor and hospital listed above.

By signing below, I authorize the release of my child's protected health information as described above.

Parent/Guardian Name: (print name) _____

Parent/Guardian Signature: _____Date: _____