



P.O. Box 237~Brooklyn , NY 11228 (917) 496-7534

Consent for Release of Protected Health Information

This form must accompany the Application for Financial Assistance for FLMF to provide assistance.

Section 1- Patient/ Guardian Release

I, _____ (Circle) Patient, Parent, Guardian, Legal Custodian of :

_____ SSN: ____-____-____ DOB: ____/____/____

Name of Patient

Authorize the physicians and staff of the facility or medical practice treating the patient to release to:

The Francesco Loccisano Memorial Foundation, Inc., P.O. Box 237, Brooklyn, NY 11228

Information is being released for the following purpose: to qualify for an award/ contribution from FLMF, Inc. a not for profit organization. In the event no date, event, or condition is specified for expiration, this consent expires in ninety (90) days from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon it. I freely and voluntarily give this consent.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

The Information I authorize for release may include records which may indicate the presence of a communicable or venereal disease which may include , but is not limited to disease such as hepatitis, syphilis, gonorrhoea, and the human immunodeficiency virus, known as Acquired Immune Deficiency Syndrome (AIDS).

X _____

Signature of Parent/Guardian

Date

Section 2-Physician Certification

I certify that the patient listed in this application is **currently receiving treatment** from

Name of hospital or treatment facility

Physician Signature

Date