



A Spark of Inspiration

Request for release of private and health information

Client's first & last name:

DOB:

I authorize A Spark of Inspiration to send, receive and exchange information with:

for the purpose of support planning and coordination of services related to the community support plan.

I understand that these records are protected under state and federal privacy laws and cannot be disclosed without your written consent unless otherwise provided for by state and federal law. I understand that A Spark of Inspiration will use my data in accordance with federal Health Insurance Portability and Accountability Act (HIPAA). These laws protect your private information and to give you notice of our legal duties and practices to protect private and confidential information.

Unless earlier revoked, this authorization will expire 366 days from signing.

Signature

Date

Printed name

Relationship

I understand that I may revoke this authorization at any time by notifying A Spark of Inspiration in writing and emailed to info@spark2hope.org. However I also understand that such a revocation will not have an effect any information already used or disclosed by A Spark of Information before we have received notice.