ROHHAD FIGHT INC.

3 Surrey Lane
Hempstead, NY 11550
rohhadfight@aol.com

HIPAA AUTHORIZATION

I_____hereby authorize the use of my child's health information as described in this authorization.

1. Specific person/organization authorized to receive and use the information:
    - ROHHAD FIGHT INC.
2. Purpose of the request:
    - TO BE CONSIDERED FOR ASSISTANCE WITH MEDICAL BILLS AND OR OTHER EXPENSES ASSOCIATED WITH MY CHILD HAVING BEEN DIAGNOSED WITH ROHHAD.
3. Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying ROHHAD FIGHT INC. in writing at 3 Surrey Lane, Hempstead, NY 11550. I understand the revocation is only effective after it is received and logged by the Directors. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
4. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
5. I understand that I am entitled to receive a copy of this authorization.
6. I understand this authorization will expire six months from the date of signing.
7. The Organization will not condition payment or eligibility for assistance on receipt of an authorization.

_____ _____

Parent or Guardian Signature Date