

HIPAA AUTHORIZATION AND WAIVER

Now comes the undersigned, _____, with a residence address of _____, stating that I am an applicant for receiving cancer care financial assistance from Jamestown Families Cancer Care, Inc. ("JFCC"), an Ohio non-profit corporation, and am providing personal healthcare information to this organization directly and through my physicians and other medical professionals as part of that application process.

I am willingly providing this information to JFCC directly about my cancer diagnoses, care, medicines, and treatments based upon my medical records, the professional opinions of my physicians and medical staff, and related healthcare organizations.

In addition, in order for JFCC to receive and process this information on my behalf relating to such application, it is necessary for me to execute this Health Insurance Portability and Accountability Act of 1996 ("HIPAA") authorization and waiver in favor of JFCC to allow its representative to communicate with me directly and the other persons referenced herein.

Therefore, for the reasons and purposes set forth above, I hereby authorize any physician, medical personnel, hospital, health care institution, pharmacist, or any other medical service provider, to release any and all relevant information to the determination of my cancer diagnoses, care, medicines, and treatments, to:

Attorney-In-Fact: **Jamestown Families Cancer Care, Inc.**,
c/o _____,
Address: P.O. Box 35
Jamestown, Ohio 45335
Phone No.: _____

upon the presentation of said documents to which this form is attached as an Addendum to the above-mentioned medical providers.

This authorization and waiver are fully understood and are made voluntarily. I understand I have the right to revoke this authorization and waiver at any time. I further understand if I revoke this authorization and waiver, I must do so in writing.

In addition, this authorization to release information and waiver of privacy under United States HIPAA protection laws specifically includes an authorization of any financial institution or medical provider to communicate with and release information to the above duly appointed Attorney-In-Fact to obtain information, documents, medical records, and/or financial records in order to comply with additional federal and state laws and regulations as necessary.

I understand the purpose and effect of this document and sign my name to this HIPAA authorization and waiver form on _____, 202__, at _____, Greene County, Ohio.

[Print Name] _____

STATE OF OHIO)
) ss.
COUNTY OF GREENE)

BE IT REMEMBERED, that on the _____ day of _____, 202__, before me, a Notary Public in and for said State, personally came _____, to me known to be the person described in the foregoing document, and who acknowledged the signing thereof to be their voluntary act, for the uses and purposes herein mentioned.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my notarial seal, on the day and year last above mentioned.

Notary Public

This Instrument Was Prepared By: David P. Suich, Esq., McNamee Law Group, LLC, 2625 Commons Blvd., Beavercreek, Ohio 45431, Tel. (937) 427-1369, dsuich@mcnameelaw.com