Standard Authorization Form

for

_____

Name of Patient

I authorize The Principle Foundation to collect or obtain from the above named Patient's Christian Science care provider(s) the following information:

> Invoices and related documents that may contain description of services provided by the care provider to the Patient.

Purpose

The purpose of this disclosure of information is to allow The Principle Foundation to evaluate qualification of the Patient for funding assistance relating to the care provider's provision of Christian Science nursing services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to The Principle Foundation at info@nfcsn.org or 10670 Barkley St, Overland Park, KS 66212. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions

I further understand that my Christian Science care provider(s) will not condition the Patient's treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:

Denial or revocation of funding support for Christian Science nursing services by The Principle Foundation.

Form of Disclosure

The Principle Foundation may collect or obtain information as permitted by this authorization in any manner that it deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Authority

Please describe your authority to act for the Patient:

( ) I am the Patient.

( ) I am acting on behalf of the Patient. Explain (e.g., POA): _____

( ) I am the parent/legal guardian of the Patient who is a minor.

_____	_____	_____
Printed Name	Signature	Date