OneOrlando Fund

Authorization for Release of Medical Information

If you need assistance with this form, please call the VictimConnect Resource Center at ***855-4-VICTIM*** *(855-484-2846) or email* ***OneOrlando@ncvc.org****. Learn more about the Fund's protocol at* **www.OneOrlando.org**.

I am the Fund Administrator of the OneOrlando Fund (the "Fund"). The attached Authorization for Release of Medical Records authorizes the Fund Administrator to obtain health records for the referenced person who has filed a claim for compensation with the OneOrlando Fund (the "Claimant").

By submitting this authorization, the Claimant authorizes OneOrlando Fund to collect medical records from the Claimant's healthcare providers relating to the nature of the injury and the number of nights of hospitalization for injuries sustained as a result of the tragic shootings at the Pulse Nightclub on June 12, 2016, or any other medical record information required by the Fund to substantiate a claim. The information obtained from the Claimant's healthcare providers under this authorization will be used by the Fund Administrator solely to confirm the dates of hospitalization or emergency room treatment, and the nature of the physical injury, to distribute payment to the Claimant pursuant to the eligibility requirements of the OneOrlando Fund Protocol.

Please complete, sign, and return the attached document to the address shown below. (If you are an Authorized Representative of a minor, incapacitated, or incompetent person, please provide information for the Claimant, and sign and return this document to the address shown below.)

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Please return this form to:

Fund Administrator: OneOrlando Fund
c/o National Center for Victims of Crime
2000 M Street NW, Suite 480
Washington, DC 20036

Authorization for Release of Medical Records

Authorization for Use and Disclosure of Protected Health Information
Pursuant to the Health Insurance Portability and Accountability Act of 1996

This form gives your health care providers written authorization to release your health information to the persons you have named below.

NAME OF CLAIMANT

FIRST NAME | MI | LAST NAME

DATE OF BIRTH / / SOCIAL SECURITY NUMBER - -

1. I, _____ authorize the health care providers listed below to disclose my Personal Health Information ("PHI") including my health care records as follows: the providers may provide any PHI or health care record(s) required to confirm my hospitalization or treatment for injuries sustained as a result of the tragic shootings at the Pulse Nightclub on June 12, 2016, including but not limited to the nature of the injuries sustained and the dates of hospitalization. I understand that due to the complexity of the claims process, and provider policies and limitations on releasing health care records and PHI, the information provided under this authorization and release may include my complete health care record for hospital admissions occurring on, about, or after June 12, 2016. The information obtained from the Claimant's healthcare providers under this authorization, will be used by the Fund Administrator solely to perform his duties pursuant to the OneOrlando Protocol including: confirmation of eligibility and distribution of payment to the Claimant pursuant to the criteria and requirements of the OneOrlando Fund Protocol. (If the Claimant is a minor or an incapacitated adult, this form must be signed by a parent or legal guardian of the Claimant.)

   Health Care Provider/Hospital/Physician:

   _____ Tel. No. _____

   _____ Tel. No. _____

   _____ Tel. No. _____

2. I hereby authorize the release of my health records to the following specific entity:

   Fund Administrator, OneOrlando Fund
   c/o National Center for Victims of Crime
   2000 M Street, NW, Suite 480
   Washington, DC 20036
   (855) 484-2846

3. This authorization of the release of my PHI covers any records related to treatment I received during the period from June 12, 2016 to September 11, 2016, even if such records were created outside of this period. This authorization shall be in force and effect until the distribution of the OneOrlando Fund has been completed.

4. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. I understand that this authorization is voluntary and that I have the right to revoke this authorization, in writing, at any time by notifying the Fund Administrator at the address shown above. I also understand that I do not need to sign this authorization in order to obtain health treatment or to receive or be eligible to receive benefits for coverage of health treatment.

6. I understand that once disclosed to the recipient my health records may not be protected by federal privacy law and could be further disclosed to others without my authorization.

7. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining compensation from OneOrlando Fund.

Signature of Claimant/Patient: _____ Date: ____ /____ /____

Signature of Guardian or
Authorized Representative:_____ Date: ____ /____ /____

Keep original, and give copies to your health care provider, agent, and family member.