HIPAA Release of information
AUTHORIZATION FORM

I, _____hereby grant access to my personal health information to **YES You Can Too** (BeatLiverTumors.org) and its affiliates, its employees and agents. This information is to support insurance claim assistance activity to be filed regarding my diagnosis and treatment of _____.

This authorization is valid for 180 days from the date of my/my representative's signature below.

I understand that I have a right to revoke this authorization by providing written notice to **YES You Can Too.**

I further understand that this authorization is voluntary and that I may refuse to sign this authorization.

Name of Patient: _____

Signature of Patient : _____

Date:_____

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____

Liability Waiver

For all activities and outcomes related to insurance appeal filings:

I _____ here by release **YES You Can Too** and any of its affiliates, employees or agents from any liability and/or damages resulting from the appeal filing assistance provided to me at no charge.

YES You Can Too makes no promises or guarantees as to the result(s) and/or outcome(s) of these activities.

I agree to indemnify and defend **YES You Can Too** from any claims, causes of actions and damages that may result from insurance appeal decisions from my family, representatives or assignees.

I HAVE READ THIS DOCUMENT AND UNDERSTAND IT. I FURTHER UNDERSTAND THAT SIGNING THIS WAIVER I MAY BE SURRENDERING CERTAIN LEGAL RIGHTS.

Date:_____

Signature:_____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patient's behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____