

CONSENT AND RELEASE
CHAPTER SERVICES AND EQUIPMENT

Note: Although it is our understanding and belief that The ALS Association Greater Philadelphia Chapter is not a Health Care Provider as defined by the Health Insurance Portability and Accountability Act (“HIPAA”), and, therefore is not subject to the provisions of that law, nevertheless your privacy is important to us. This form allows for the obtaining and distribution of medical information in a manner that provides us with reasonable flexibility using that information while endeavoring to protect your privacy. We appreciate your understanding and cooperation in helping us to accomplish these purposes for the mutual benefit of the ALS community.

This consent can be revoked at any time, in writing, by the individual authorizing this Consent and Release.

The Greater Philadelphia Chapter, Amyotrophic Lateral Sclerosis Association (“Chapter”) is an organization dedicated to the discovery of the cause of ALS through research while providing patient support, information and education, and, as such, has been determined by the Internal Revenue Service to be a tax exempt organization:

The following individual, _____, is a patient with ALS (“Patient”) who anticipates receiving, and/or has received, from or through the auspices of the Chapter, services and/or the use of equipment designed to help Patient deal more effectively and/or comfortably with ALS:

The specific information that may be requested or disclosed in connection with the Chapter’s provision of services is as follows: Issues related to medical condition.

The available services provided by the Chapter include, among other things, in-home care; wheelchair accessible van transportation; support group availability; equipment loan and/or maintenance – medical and communication; family counseling; numerous and sundry recreation programs; nursing home care (“Services”).

In consideration of the above and intending to be legally bound hereby, and being authorized and competent to do so, Patient, and/or his or her authorized representative, on behalf of Patient, Patient’s family, and caretakers of Patient, and their heirs, representatives and assigns (each hereinafter called “Releasers”), does sign this Consent and Release in favor of Chapter, its Directors, officers, employees, volunteers, agents and their heirs, representatives, and assigns (each hereinafter called “Releasees”), and does agree as follows:

1. Releasers, being duly authorized and competent to do so, release and discharge all of the Releasees, from all claims, liability, causes of action, and judgments, past, present, and future, known or unknown at the time of signing of this Consent and



Release, particularly arising from Services or equipment available to Patient, or Patient's family, or to any of the Releasors, by or through the auspices of the Chapter.

2. Releasors, being duly authorized and competent to do so, consent to and fully permit the use, release and communication of all medical and health information concerning Patient to or from health insurance companies and medical or medically related entities and/or individuals and health care providers, such as health practitioners, hospitals, clinics, equipment companies, drug companies, pharmacists, and ambulance companies, for all purposes consistent with all available services with which the Chapter is involved, whether or not listed above. The specific person at the Chapter who is responsible for compiling and storing patient information is Patient Services Personnel.
3. Releasors acknowledge that they may, from time to time, receive from the Chapter solicitations, informational mailings, newsletters, and/or announcements of events. Upon receipt from Releasors(s) of a written request, the Chapter shall refrain from sending Releasors(s) any or all such mailings.
4. Releasors agree that a photocopy and/or facsimile copy of this Consent and Release may be relied upon in the same manner as the original.
5. Patient and related Releasors further state that they have read this Consent and Release, that they understand and agree to its contents, and that they have been given the opportunity to review it with their attorney prior to signing it.

IN WITNESS WHEREOF, we have hereunto set our respective hands and seals this _____ day of _____, 201 ____.

PATIENT

FAMILY MEMBER

(By _____, if not the patient being duly authorized).

WITNESS

WITNESS