Red Bird
LEGACY FOUNDATION

APPLICATION

Send completed application to:

P.O Box 247
Bethel, DE 19931

sherri@redbirdlegacyfoundation.org

Who's completing this application?

O Patient/Self O Spouse O Agent O Other: _____

Personal Information

Patient's Name: _____

Spouse's Name: _____ O N/A

Address: _____

Phone No.: _____ Email: _____

Date of Birth: _____ Age: _____

Child(ren)'s Information

Name/Nickname: _____

Age: _____ Gender: _____ Special Needs? O Y or O N

Relationship? O Biological O Adopted O Step

Name/Nickname: _____

Age: _____ Gender: _____ Special Needs? O Y or O N

Relationship? O Biological O Adopted O Step

Name/Nickname: _____

Age: _____ Gender: _____ Special Needs? O Y or O N

Relationship? O Biological O Adopted O Step

Name/Nickname: _____

Age: _____ Gender: _____ Special Needs? O Y or O N

Relationship? O Biological O Adopted O Step

Medical Information

Diagnosis: _____

_____

Prognosis: _____

_____

Physician's Statement

I am the treating physician of the Patient named in this application. He/she has been under my medical care since _____.

The Patient was diagnosed in _____. The Patient's prognosis is outlined above. I believe that if the Patient **refused** medical treatment, his/her life expectancy would be less than 2 years.

In my opinion, the Patient is of sound mind and has the capacity to sign legal documents (i.e. Will, Power of Attorney, etc.).

Physician's Name: _____

Physician's Signature: _____

Address: _____

Phone No.: _____ Email: _____

Patient's Statement

I am the Patient named in this application. I certify that the information provided by me is true and correct to the best of my knowledge and belief. I understand that no promises or assurances have been made by Red Bird Legacy Foundation to provide services to me or my family. I acknowledge that services will be granted at the sole and complete discretion of Red Bird Legacy Foundation. If granted, I agree to sign all necessary documents before services begin.

_____ _____

Date Patient's Signature

Printed Name: _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I grant Red Bird Legacy Foundation ("RBLF"), its board members, officers, volunteers, and authorized representatives, the power and authority to serve as an authorized recipient for all purposes of HIPAA. I specifically authorize RBLF to request, receive, and review any information regarding my physical health, including all HIPAA-protected health information, including medical and hospital records. I specifically authorize my health care providers to release any requested medical records to RBLF.

This authorization shall expire once the Patient has completed services with RBLF, or a final determination has been made that Patient is not eligible to receive services.

I may revoke this authorization at any time. I understand that:

- If my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I may refuse to sign this authorization and that my refusal to do so will not affect my ability to obtain treatment or payment or eligibility for benefits.
- Since RBLF is not a healthcare provider or health plan covered by federal privacy regulations, such information, once released, will no longer be protected by these regulations and could potentially be re-disclosed by the recipient.

Waiver & Release of Liability

I acknowledge that I have voluntarily applied to receive services provided by RBLF. I waive, release, and discharge RBLF, its board members, officers, volunteers, and authorized representatives, from any and all liability arising from my involvement with RBLF. I further agree to indemnify and hold RBLF, its board members, officers, volunteers, and authorized representatives, harmless from all judgment, cost, claim for loss, damage, or injury arising from my involvement with RBLF.

Assignment of Rights & Consent to Publish Information

I give RBLF full rights to publish my personal information (i.e. name, family members, and diagnosis) and any photographs taken during my involvement with RBLF on RBLF's website and on RBLF's social media sites. I relinquish my rights to any future compensation for reproduction, publication, or use of the aforesaid information by RBLF in its print or electronic correspondence, or on its website. RBLF is in no way obligated to publish or use my personal information.

I am the Patient named in this application. My signature below represents my Authorization, Waiver & Release, and Assignment & Consent as outlined above.

_____ _____

Date Patient's Signature

Printed Name: _____