NOW Inc.
NO OPPORTUNITY WASTED

AUTHORIZATION TO USE OR DISCLOSE HEALTH CARE INFORMATION

Granted to No Opportunity Wasted *Education through Experience* also referred to as "the Traveling Guardians"

Student Name: _____ Date of birth: _____

I. **My Authorization**

You may use or disclose the health care information for all my medical information in my medical record for the date(s):

_____

You may disclose this health care information to *the Traveling Guardians* only to plan medical treatment if/when necessary.

This authorization ends: _____ in 30 days from the date of the HBCU tour.

II. My Rights

I understand if I sign this authorization, I am granting *the Traveling Guardians* access to my health care information for the purpose of assisting in the planning of the treatment that I could be offered.

I may revoke this authorization in writing. If I do, it would not affect any actions already taken by *the Traveling Guardians* based upon this authorization.

Once my health care information is disclosed, the person or organization that receives it may re-disclose it. I understand that privacy laws may no longer protect this information.

_____ _____
Legally Authorized Individual Signature Date and Time

_____ _____
Printed name, if signed on behalf of the student Relationship to student (parent, legal guardian)