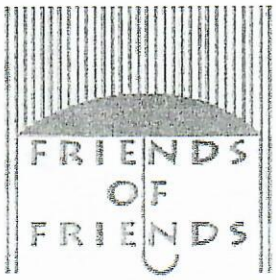

Authorization to Use or Disclose My Health Information
Privacy Policy

Friends of Friends will maintain the privacy of your health information as required by law.
Friends of Friends agrees to not use or further disclose any Personal Health Information other than as specifically permitted or required by this agreement or as required by law. We will use appropriate, reasonable safeguards to prevent use or disclosure of this information.

I. My Authorization

When I request assistance with payment for medically related bills, Friends of Friends may use, disclose, or discuss my health information with the entity that issued the bill - a pharmacy, doctor's office or other medical institution.

II. My Rights

I may revoke this authorization in writing. I understand that a letter to Friends of Friends will terminate this agreement.

Please sign and mail to:

Friends of Friends, P.O. Box 812 Langley WA 98260

Patient or legally authorized individual signature _____ Date _____ Time _____

Printed Name _____ relationship if parent or legal guardian signed on behalf of patient _____

3/14/11