smilefundusa@gmail.com

1700 Aviara Pkwy, #130141
Carlsbad, CA 92013

HIPAA Authorization Form

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____

Authorization Purpose
Smile Fund USA and MedAid Financial LLC work in collaboration to assist patients in receiving grants for necessary dental procedures. This authorization permits Smile Fund USA and MedAid Financial LLC to collect, use, and disclose my protected health information for the purpose of applying for a grant to fund the following dental procedure(s):

Name the dental procedure you apply for: _____

Authorization Scope
I understand that my health information, including details about the dental procedure I require, may be shared with Smile Fund USA, MedAid Financial LLC, and designated local dental providers who specialize in the specific dental procedure(s) described above. This information will be used only for grant application, screening, and funding purposes and will not be disclosed to any other entities.

Financial Information Privacy
I understand that any financial information (monthly income, savings, etc.) I provide for this grant application will not be sold, shared, or disclosed beyond Smile Fund USA and MedAid Financial LLC. This information will only be used to assess eligibility for the grant and ensure compliance with restricted donations.

Right to Revoke
I understand that I may revoke this authorization at any time by providing written notice to Smile Fund USA and MedAid Financial LLC at the contact information below. However, I understand that any action taken based on this authorization prior to revocation is valid.

Expiration
This authorization will expire one year from the date of my signature or upon completion of the dental procedure for which I am applying for funding, whichever comes first.

Contact Information for Questions or Revocation
Smile Fund USA
Address: 1700 Aviara Pkwy, #130141, Carlsbad, CA 92013
Email: smilefundusa@gmail.com

Patient Acknowledgment and Signature
I have read and understand this authorization form. I voluntarily authorize the disclosure of my health information as described above.

Signature: _____

Date: _____