



**Tara Ann Ralph**  
**FOUNDATION**

**CONFIDENTIAL APPLICATION**

*The Tara Ann Ralph Foundation is a non-profit organization. The foundation considers requests to cover medical expenses or expenses related to a medical illness not attainable through any other source. Please print clearly and complete the entire application.*

Date \_\_\_\_\_ Requested Amount \_\_\_\_\_

Patient \_\_\_\_\_ Parent or Legal Guardian \_\_\_\_\_

Applicant (if different from above) \_\_\_\_\_ Contact (if different from above) \_\_\_\_\_

**Medical Resources** (Please list all medical payment plans; i.e. insurance, medical saving plans, etc., even if any have been exhausted) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referral Name** \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email Address \_\_\_\_\_

**Please send all information or notifications regarding this application to:** \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ Email Address \_\_\_\_\_

**Treatment Plan** (Please include the medical diagnosis of the illness and the anticipated result of the treatment and/or medical services) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Medical Providers or Suppliers** *(Funds are paid directly to the provider/supplier)*

Name/Provider 1 or Supplier 1

Address

Telephone Fax

**Amount** \$

Name/Provider 2 or Supplier 2

Address

Telephone Fax

**Amount** \$

Name/Provider 3 or Supplier 3

Address

Telephone Fax

**Amount** \$

Name/Provider 4 or Supplier 4

Address

Telephone Fax

**Amount** \$

**Supplemental Services** *(If the requested funding is for supplemental services, and not for direct medical care, please provide details)*

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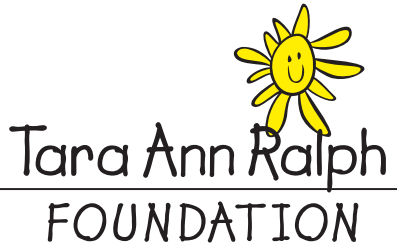
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Please return the attached "Authorization for Release of Medical Records" form, completed and signed with your Tara Ann Ralph Foundation application to: Tara Ann Ralph Foundation, P.O. Box 39, Rochelle Park, NJ 07662.

DO NOT WRITE BELOW THIS LINE

<b>Foundation Use Only</b> (Please print and sign your name below)			
Reviewed by	Date	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined
Reason			
Reviewed by	Date	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined
Reason			
Reviewed by	Date	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined
Reason			

The Tara Ann Ralph Foundation is a private foundation within the meaning of Section 509(a) of the Internal Revenue code and is exempt from Federal Income taxation under Section 501(c)(3) of the Code. Your contribution is tax deductible to the extent provided by law. You should consult with your tax advisor.



AUTHORIZATION for RELEASE  
of MEDICAL RECORDS  
*HIPAA Compliant/Pursuant to 45 CFR 164.508*

THIS AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND DATED

TO _____ Name of Healthcare Provider/Physician/Facility	RE _____ Patient Name
_____ Street Address	_____ Street Address
_____ Street Address/Line 2	_____ Street Address/Line 2
_____ City/State/Zip Code	_____ City/State/Zip Code
	_____ Date of Birth
	_____ Social Security Number

I authorize the disclosure of all protected health information and I specifically direct that the records custodian of all covered entities under HIPPA identified above disclose full and complete protected health information including, but not limited to, the following:

\_\_\_\_\_  
*(Describe information to be used or disclosed that identifies the information in a specific and meaningful way.)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Information about diagnosis or treatment for alcohol/substance abuse and HIV/AIDS may be disclosed as follows:  
(Check all that apply)

- |   |    |   |
|---|----|---|
| <input type="checkbox"/> YES, disclose HIV/AIDS information           | OR | <input type="checkbox"/> NO, do not disclose HIV/AIDS information           |
| <input type="checkbox"/> YES, disclose alcohol/drug abuse information | OR | <input type="checkbox"/> NO, do not disclose alcohol/drug abuse information |

This protected health information is disclosed for the following purposes:

- This disclosure is made at my request in compliance with 45 CFR 164.508(c)(1)(iv).
  - Other (describe) \_\_\_\_\_
- \_\_\_\_\_

You are authorized to release the foregoing records to the following representatives of the patient who have agreed to pay reasonable charges made by you to supply copies of such records:

\_\_\_\_\_  
Name of Representative

\_\_\_\_\_  
Representative Capacity (e.g.,Attorney,Records Requestor,Agent, etc.)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip Code

I acknowledge this authorization may be revoked, in writing, by sending written notification to you at the above address. However, I understand that any actions already taken in reliance on this Authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under HIPAA privacy rules.

It is my understanding that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization, unless a condition set forth at 45 CFR 164.508(b)(4) applies.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the requested records. This authorization shall be in force and effect until:

Date \_\_\_\_\_

Event (describe) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

Dated \_\_\_\_\_

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority to Sign for Patient (attach Authorization documents)

\_\_\_\_\_  
Witness

Dated \_\_\_\_\_