610 N Main Ave
San Antonio, TX 78205
(210) 619-6828
www.TheProstheticFoundation.org

Prosthetic Limb Grant Application

Please complete ALL fields and submit ALL requested documents. Incomplete applications will not be considered.

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED

I waive all liability that may arise because of treatment I may receive through services funded by The Prosthetic Foundation. I certify that the information provided in this application is correct to the best of my knowledge. I understand that any false statement or misrepresentations will disqualify me from grant disbursement, and that grant funds will only be disbursed to the prosthetics facility that fabricates and delivers my prosthesis.

I authorize The Prosthetic Foundation to validate the information presented here through a consumer report pursuant to Section 604(a)(2) of the Fair Credit Reporting Act or other reasonable means, as necessary.

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HIPAA Medical Information Release

Primary Care Physician

Purpose: **Prosthetic Limb Grant Application**

I hereby authorize and request the exchange of information between The Prosthetic Foundation and the above-named professional/organization as follows:

I understand that release of confidential information is subject to State and Federal Laws and that they govern the confidentiality of alcohol and drug dependent persons (42CFR Par 2) and prohibits the disclosure of (1) psychotherapy notes, (2) information complied in reasonable anticipation, or for the use in civil, criminal, or administration action or proceedings. I am aware of my right to receive a Notice of Privacy Practices from The Prosthetic Foundation.

I may revoke this authorization at any time by notifying The Prosthetic Foundation in writing, except to the extent that: a) action has been taken in reliance on this authorization; or, b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

By signing this release, I authorize the release of my medical information as depicted above between my primary care physician or facility and The Prosthetic Foundation which may include drug and alcohol abuse, and disclosure of the results of HIV antibody blood testing and information concerning AIDS (Acquired Immune Deficiency Syndrome) information through one year from the date of my certification below.

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

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HIPAA Medical Information Release

Texas Certified Prosthetist

Purpose: **Prosthetic Limb Grant Application**

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Photo and Video Release

The undersigned does hereby authorize The Prosthetic Foundation and designees to

Take and reproduce photographs, motion pictures, video and/or audio tapes, slides, or other media of the above-named person in connection with the diagnosis, care and treatment, or functional capacity of the above-named facility. Use of such materials and the person's name in connection with any publication or broadcast including, but not limited to, newspapers, television, radio, books, brochures, magazines, motion pictures, social media and organization's website; And is not limited to scientific or educational purposes and may be used in such manner and in such times and in such places as The Prosthetic Foundation shall determine, without restriction on its sole discretion.

I waive all rights that I may have to any claims for payment or royalties in connection with any exhibition, publication, or broadcast of the above regardless of whether such exhibition, publication, or broadcast is philanthropically, commercially, institutionally or privately sponsored and regardless of whether a fee for admission or rental is charged.

I release The Prosthetic Foundation, employees, board members, volunteers, and consultants from any liability in connection with the use of such materials. I understand that this authorization will remain effective indefinitely unless revoked in writing. I make such authorization on my own free will or on behalf of a minor to whom I am a biological parent to or legal guardian of.

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CHECKLIST

Use this checklist to ensure that you are including all of the required documents with your completed and signed application.

Include a copy of the bills you have reported on this application