AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO MATCHED RECIPIENT(S)

Donor: liban fredis

DOB: 1985-08-14

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California Law, this authorization for disclosure is needed in order for us to share your protected health information with a 3rd party. By completing this form, you are granting permission for the uses and disclosures below. Please review and complete this form carefully.

I, _____ (Donor) give permission to Acorn Connections to use with and disclose my private health information (including medical treatment, test results, mental health, sexually transmitted infections, drug and alcohol use, and physical and/or sexual abuse) to any Recipient(s) that I match with through the platform. I understand that I can change and/or revoke this permission at any time.

Donor:	liban fredis	DocuSigned by: liban fredis C00292C84B2B400...	2023/01/05
	Print Name	Signature	Date