

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION 2012**

**Patient Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

**Patient Address** \_\_\_\_\_

**Telephone** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_  
(if necessary to obtain records)

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure (give name, address and phone of your physician/s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information I authorized disclosed is:

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

- |                                 |                                   |
|---------------------------------|-----------------------------------|
| ___ Abstract of Medical Records | ___ Any and All (Medical Records) |
| ___ Entire Medical Record       | ___ Billing/Itemized Statements   |
| ___ X-rays and Imaging Films    | ___ Other: _____                  |

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to and used by the following individual or organization:  
Staff of Groundwork Guatemala: Kevin Holmes, Virginia Holmes, Randy Stauner, Rachel Stauner  
as well as: \_\_\_\_\_
5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in Title 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
7. I understand there may be a fee for copying these records in accordance with Title 45 CFR 164.524 and IC 16-39-9-3.
8. The above authorized representative must be able to prove their identity.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if legal representative)

\_\_\_\_\_  
Signature of Witness (if not signed by patient)

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE 2012**

**NOTICE: READ THE FOLLOWING PAGE BEFORE COMPLETING THIS FORM**

POWER OF ATTORNEY made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

1. I, the undersigned, hereby appoint (insert name and address of agent)

\_\_\_\_\_  
\_\_\_\_\_  
as agent to act for me in my name to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy and direct the disposition of my remains.

2. The powers granted above shall be subject to the following rules or limitations (if none, leave blank):

\_\_\_\_\_  
\_\_\_\_\_  
(The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with the subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial the statement, but do not initial more than one.)

\_\_\_\_\_ I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burden of the treatment outweighs the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality, as well as the possible extension of my life, in making decisions concerning life-sustaining treatment.

\_\_\_\_\_ I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physicians believe to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

\_\_\_\_\_ I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

3. This power of attorney shall become effective on \_\_\_\_\_.

4. This power of attorney shall terminate on \_\_\_\_\_.

5. If any agent named by me shall die, become legally disabled, resign, refuse to act or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

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

6. If a guardian of my person is to be appointed, I nominate the following to serve as guardian (if same as agent, leave blank):

\_\_\_\_\_

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed: \_\_\_\_\_  
Principal

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form, in my presence.

\_\_\_\_\_  
Witness Residing at

(You may, but are not required to request your agent and successor agents to provide specimen signature below. If you include specimen signature in the Power of Attorney, you must complete the certification opposite the signature of the agents.)

Specimen signatures of agent (and successors) I certify that the signature of my agent (and successor) are correct

\_\_\_\_\_  
(Agent) (Principal)

\_\_\_\_\_  
(Successor agent) (Principal)

\_\_\_\_\_  
(Successor agent) (Principal)

**NOTICE: READ THE INFORMATION BELOW ABOUT THE DURABLE POWER OF ATTORNEY  
FOR HEALTH CARE BEFORE COMPLETING THE REVERSE SIDE OF THIS FORM.**

1. The Purpose Of The Durable Power Of Attorney For Health Care: The purpose of this power of attorney is to give the person you designate (in the form this person is referred to as your “agent”) broad powers to make health care decisions for you (in the form you are referred to as the “principal”), including power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home or other institution. This form does not impose a duty on your agent to exercise granted powers; but when a power is exercised your agent will have to use due care to act for your benefit and in accordance with this form. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name successor agents under this form but not co-agents, and no health care provider may be named. Unless you expressly limit the duration of this power in the manner provided below, until you revoke this power or a court, acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you become disabled. The powers you give your agent, your right to revoke these powers and the penalties for violating the law are explained more fully in the state laws and statutes where you live and reside. The law permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand you should ask a lawyer to explain it to you.
2. Grant Of Power Is Intended To Be As Broad As Possible: The grant of power found in paragraph 1 on the reverse side of this form is intended to be as broad as possible so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent’s power or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in paragraph 2 on the reverse side of this form.
3. Amending or Revoking the Power of Attorney: This Power of Attorney may be amended or revoked by you at any time and in any manner while you have the capacity to do so. Absent amendment or revocation, the authority granted in this Power of Attorney will become effective at the time this Power is signed and will continue until your death, and beyond if anatomical gift, autopsy or disposition of remains is authorized, unless a limitation on the beginning date or duration is made by you. (See paragraph 3 and 4 on the reverse side of this form.)
4. Appointment of Successor Agents: If you wish to name successor agents, insert the names and addresses of such successors in paragraph 5 on the reverse side of this form.
5. Naming a Guardian of Your Person: If you wish to name a guardian of your person in the event a court decides that one should be appointed, you may, but are not required to do so, by inserting the name of such guardian in paragraph 6 on the reverse side of this form. The court will appoint the person nominated by you if the court finds that such appointment will serve your best interests and welfare. You may, but are not required to, nominate as your guardian the same person named in the form as your agent.

**HEALTH HISTORY 2012**

Patient Full Name \_\_\_\_\_

Patient Address \_\_\_\_\_

Telephone \_\_\_\_\_ Passport # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male  Female

Physician Name \_\_\_\_\_

Physician Address \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Blood Type: \_\_\_\_\_ I have received all physician recommended immunizations: \_\_\_\_\_

Allergies to Medications: \_\_\_\_\_

Medical Conditions:

- |  |             |  |             |
|--|-------------|--|-------------|
| <input type="checkbox"/> Hypertension                  | Date: _____ | <input type="checkbox"/> HIV/AIDS              | Date: _____ |
| <input type="checkbox"/> Heart Attack or Heart Surgery | Date: _____ | <input type="checkbox"/> Stroke                | Date: _____ |
| <input type="checkbox"/> Hepatitis                     | Date: _____ | <input type="checkbox"/> Diabetes              | Date: _____ |
| <input type="checkbox"/> Angina                        | Date: _____ | <input type="checkbox"/> Special Dietary Needs | Date: _____ |
| <input type="checkbox"/> Pregnancy                     | Date: _____ | <input type="checkbox"/> Other _____           | Date: _____ |

Current Medications (include generic name, strength and dosage):

| <u>Medical Conditions Requiring Doctor's Approval</u> |   |
|---|---|
| Asthma  | Tuberculosis  |
| Cardiac condition                                     | HIV   |
| Hepatitis A, B or C                                   | Pregnancy   |
| Insulin dependent diabetes                            | Recent infection, e.g., pneumonia, bronchitis, etc. |
| Pulmonary condition                                   | Recent surgery or other invasive procedure          |
| Seizure disorders                                     | History of deep vein thrombosis                     |

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

Please feel free to give additional comments on the reverse side of this Health History form.

**Emergency Contact:**

Contact #1

Contact #2

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact #: \_\_\_\_\_

Contact #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ I.D. Number: \_\_\_\_\_

**WAIVER AND RELEASE**

THIS DOCUMENT CONTAINS A FULL RELEASE OF LIABILITY AND OF POTENTIAL FUTURE CLAIMS:  
PLEASE READ CAREFULLY

In consideration of the acceptance of my application for participation in Groundwork Guatemala event, I, the undersigned, for myself, my heirs, executors, administrators and assigns, waive and release any and all claims for damages, death, personal injury, loss of property or property damage I may have, or that my subsequently accrue to me, or to my heirs, executors, administrators or assigns, as a result of my participation in a Groundwork Guatemala event. I, the undersigned, discharge and release in advance Groundwork Guatemala, its employees, representatives and Board of Directors and any other such entities involved, and their respective agents, boards, commissions, without limitation, from and any and all liability arising out of or connected in any way with my participation in the above-mentioned event, even though the liability may arise out of negligence or carelessness on the part of the persons or entities mentioned above. As consideration for my participation, I agree that Groundwork Guatemala and any other agency and/or organization involved or associated with the mission trip, shall not be responsible for any loss or damage to myself which may have resulted in any way from my participation in the mission trip, or associated with the mission team, in whole or in part. I agree to indemnify Groundwork Guatemala ministry as well as any other organizations involved with the mission trip, harmless from any and all claims, actions, suits, proceedings, cost, expense, damage and liabilities, including attorney fees, arising out of, connected with, or resulting from my participation in any phase of the process with Groundwork Guatemala ministry team, whether caused by the acts, omissions or negligence of Groundwork Guatemala ministry, as well as any other organizations involved with this mission trip or others. I fully realize that the conditions in most of the places to which I will travel are not of the same standard to which I am accustomed (i.e., political environments, judicial systems and available health care). I further realize that there are certain health and detainment risks, as well as other risks to me and my property, including, but not limited to, hazardous traffic, poorly constructed roads, dangers resulting from military or political problems, sickness, disease, injury or death that may occur on, or related to this trip. I acknowledge that my participation in Groundwork Guatemala event is voluntary and done at my own risk. I voluntarily assume all risks of loss, damage or injury that may be sustained while participating in the above -mentioned event. I attest that I am physically fit and sufficiently trained for this kind of event. I agree that medical or other services rendered to me by, or at the instance of any of the persons or entities mentioned above is not an admission of liability to provide or to continue to provide any such services, and is not a waiver by any of the persons or entities mentioned above of any right under this waiver and release.

I further understand that serious accidents may occasionally occur and that I may sustain mortal or serious personal injuries or property damage as a consequence of such participation. Knowing the risks of participating in the event, I nevertheless agree to assume those risks and to release and hold harmless all of the persons and entities mentioned above who, through negligence or carelessness or otherwise, might be liable to me (or my heirs, personal representatives or assigns) for damages. I agree to accept and abide by the rules and regulations of the event as established and provided to me by Groundwork Guatemala.

In further consideration of the acceptance of my application for participation in Groundwork Guatemala event, I grant full permission to Groundwork Guatemala and agents authorized by the mission, to use photographs, videotapes and any other record of the event, including my name, likeness and voice for any legitimate purpose.

Signature of releaser: \_\_\_\_\_

Dated: \_\_\_\_\_

**RELEASE 2012**

This Release executed on \_\_\_\_\_ (date), by \_\_\_\_\_ (name),

of \_\_\_\_\_ (address),

\_\_\_\_\_ (city), \_\_\_\_\_ (county),

\_\_\_\_\_ (state), \_\_\_\_\_ (country) to Groundwork Guatemala with its principal business office located at 713 E Jasmine St, Mesa AZ 85203, and the members, employees, directors and representatives participating in the mission team experience on \_\_\_\_\_ (trip dates.)

**PARTICIPANT'S CONVENANTS**

In consideration of being permitted to observe, work for, or for any purpose participate in any way in the event or for any purposes in the work of Groundwork Guatemala, the undersigned, for himself or herself, and his or her personal representatives, heirs and next of kin, acknowledges, agrees and represents that he or she has, or will immediately on initiating any observation, work or participation does warrant that entry on such observation, work or participation constitutes an acknowledgment that he or she has inspected such observation, work or participation and that he or she finds and accepts the same as being safe and reasonably suited for the purposes of its use. The undersigned further agrees and warrants that if at any time he or she is in areas and he or she feels anything to be unsafe, he or she will immediately advise the proper officials and will leave the areas.

**Section One**

**RELEASE AND COVENANT NOT TO SUE**

The undersigned releases, waives, discharges and covenants not to sue Groundwork Guatemala or employees, directors or representatives involved in the planning, promotion or carrying out of the event and each of them, their officers and employees, all of whom for the purposes of this release are referred to as "releasees," from all liability to the undersigned, and the undersigned's personal representatives, assigns, heirs and next of kin, for any and all loss or damage, and any claim or demands for the same on account of injury to the person or property of the undersigned or resulting in death of the undersigned, whether caused by the negligence of the releasees or otherwise, while the undersigned is observing, working or participating in the event.

**Section Two**

**INDEMNIFICATION**

The undersigned agrees to indemnify and save and hold harmless the releasees and each of them from any loss, liability, damage or cost they might incur due to the presence of the undersigned observing, working for, or for any purpose participating in the above described event and whether caused by the negligence of the releasees or otherwise.

**Section Three**

**ASSUMPTION OF RISK**

The undersigned assumes full responsibility for and risk of bodily injury, death or property damage due to the negligence of releasees, or otherwise, while observing or working for or for any purpose participating in the above described event.

(CONTINUED)

**Section Four**

**SCOPE OF RELEASE AND INDEMNITY**

The undersigned acknowledges and agrees that the activities of the above-described event are potentially dangerous and may involve the risk of serious injury or death and/or property damage.

The undersigned further agrees that the foregoing release, waiver and indemnity agreement is intended to be as broad as inclusive as is permitted by the law of Indiana, and that if any portion of it is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. The undersigned has read and voluntarily signs the release and waiver of liability and indemnity agreement, and further agrees that no oral representations, statements or inducements apart from the foregoing written agreement have been made.

IF UNDER 18 YEARS OF AGE, NOTARIZED SIGNATURE OF PARENT OR GUARDIAN IS REQUIRED.

SIGNATURE OF RELEASOR \_\_\_\_\_

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_

WITNESS' SIGNATURE \_\_\_\_\_

(Acknowledgment of signature of parent or guardian, if required.)