Authorization for Release of PHI for digital sherpa™ Workshop Participant

As a digital sherpa™ workshop participant, I understand that I may elect to provide volunteers and other participants confidential medical information and protected health information ("PHI"), as covered by state or federal confidentiality laws, including the Health Insurance Portability and Accountability Act ("HIPAA").
With respect to any PHI or other confidential information I choose to disclose, I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information or PHI for the limited purpose of the digital sherpa™ program in which I am participating.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and my participation in the program will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
- I further understand that I am willingly sharing potentially important and private information with non-professionals, and that even though the volunteers have agreed to hold my information private, the organization cannot guarantee the privacy of sensitive information during a digital sherpa™ workshop or program. If not sooner revoked, this authorization shall expire one (1) year from the date below.

I have read, understand, and agree to the information above.

Signature: _____ Date: _____

Printed Name: _____