Samantha Makes It A Little Easier, Inc.
SMILE Kids Application

Applicant Information				
Last Name	First Name	M.I.	Sex	Birth Date
Street Address				Apt/Unit
City, State, Zip		Email		
Diagnosis	Treatment Location			

Parental Information		
Last Name	First Name	Phone
Street Address		Apt/Unit
City, State, Zip	Email	

Request Please attach an explanation of the applicant's need for the requested donation (no more than two pages).	
Item or Service Being Requested	Approximate Cost (If known)

Referring Health Provider Please attach a letter of recommendation from a referring health care provider (doctor, nurse, social worker, etc.).		
Last Name	First Name	Phone
Street Address		Apt/Unit
City, State, Zip		
Email		

Consent of Application
I hereby certify that the facts set forth in this application are true and complete to the best of my knowledge. I understand that if chosen to receive goods or services and part or whole of this application is falsified it may result in loss of goods or services. Signature Date

Please Submit Application Via
Fax: (757-471-4205) • Email: contact@smileasier.org
Mail: 101 West Main Street Suite 7000, Norfolk, VA 23510

Samantha Makes It A Little Easier, Inc.
("S.M.I.L.E.")
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO BE COMPLETED BY S.M.I.L.E.:

Patient Name: _____ **Social Security Number:** _____
Phone Number: _____ **Date of Birth:** _____

Persons/organizations providing the information:
Physician Name: _____
Physician Address: _____
_____
_____

Organization receiving the information:
Name: Samantha Makes It Easier, Inc.
Address: 101 W. Main St., Suite 700
Norfolk, VA 23510
(757) 333-1219

Specific description of information requested (including date(s)): _____
_____
_____
_____
_____

The information described above will be used or disclosed for the following purpose(s): _____
_____
_____
_____
_____

Expiration Date or Event: _____
If an expiration date is not provided above, this Authorization will expire one (1) year from the date of the request.

TO BE COMPLETED BY THE PATIENT OR PATIENT'S REPRESENTATIVE:

I hereby authorize the use or disclosure of my protected health information as described above. I understand that this authorization is voluntary. I understand that my ability to obtain treatment or payment for treatment will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected under HIPAA. I understand that the information to be released may include records related to behavior and/or mental health, alcohol and drug abuse treatment, HIV/AIDS, and genetics. I understand that I have a right to revoke this authorization by sending written notification to: Samantha Makes It a Little Easier, Inc., 101 W. Main Street, Suite 700, Norfolk, VA 23510. Any revocation will not affect disclosures made prior to the receipt or knowledge of the revocation. I understand that I have a right to inspect and receive a copy of the information described on this form. I agree to waive all claims against Samantha Makes It a Little Easier, Inc. for release of the requested information.

I certify that I have received a copy of this authorization.

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative: _____

Relationship to the patient: _____

WAIVER AND ASSUMPTION OF THE RISK

The undersigned parties ("Parties") hereby voluntarily execute this Waiver and Assumption of the Risk in favor of Samantha Makes It A Little Easier, Inc. ("SMILE") fully waiving and releasing SMILE from any and all claims that may result from the_____ **(ITEM)** given as a charitable benefit by SMILE to _____ **(Child's Name)**, including without limitation claims for personal injury, property damage, and death.

The Parties acknowledge that they are responsible for the selection of a product appropriate for NAME and that SMILE has not exercised independent judgment in selecting the _____ **(ITEM)**. THE PARTIES ACKNOWLEDGE THAT SMILE MAKES NO REPRESENTATIONS OR WARRANTIES WHATSOEVER WITH RESPECT TO THE _____ **(ITEM)**, INCLUDING, WITHOUT LIMITATION, ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR ANY PARTICULAR PURPOSE. The Parties acknowledge that they are responsible for the safe and supervised use of the _____ **(ITEM)** and that they will take appropriate measures to ensure that the _____ **(ITEM)** is used safely. The Parties understand that there are inherent risks in using the _____ **(ITEM)**, and, with such knowledge, they voluntarily assume those risks, individually and jointly. They agree to release and hold SMILE harmless for any liability that arises from the use of the _____ **(ITEM)**.

This Waiver and Assumption of the Risk is in addition to, and does not prejudice, SMILE's right to charitable immunity at common law. The Parties acknowledge that they are beneficiaries of SMILE's charitable purpose. The Parties further agree not to challenge SMILE's right to charitable immunity.

SIGNATURES OF THE PARTIES

By signing this, I affirm all of the above statements and make myself one of the Parties to the Waiver and Assumption of the Risk. I affirm that I fully understand the above Waiver and Assumption of the Risk. I further affirm that all the Parties, including myself, are competent to execute this Waiver and Assumption of the Risk.

_____ _____

PRINT NAME (Parent/Guardian) **SIGN** **DATE**

_____ _____

PRINT NAME (Parent/Guardian) **SIGN** **DATE**