AUTHORIZATION FOR RELEASE OF ACCOUNT INFORMATION (ARA)

To: _____ **(Name of Institution)**

_____ **(Address of Institution)**

_____ **(City, State, and Zip)**

_____ **(County)**

_____ **(Phone)**

I hereby authorize the above-named institution(s) to release, upon presentation of this authorization to **Children's Burial Assistance, Inc.,** and any of its agents, any material or information including by way of example, but not limited to the following:

1. Account information, including activities and balances for any account accepting donations for the burial/funeral expenses of _____ (insert child's name).

2. Account information, including activities and balances for any account established in memoriam for _____ (insert child's name).

3. Account information, including service selections and pricing for funeral, cremation, or other memorial services for _____ (insert child's name).

4. Account information including payments, credits, and balances for funeral, cremation, or other memorial services for _____ (insert child's name).

Account Name: _____

Account Number: _____

Account Holder: _____

Account Holder: _____

I understand that these records are confidential. I understand that by signing this authorization I am allowing the release of any account information requested to the entity, agency or person specified above. I also understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it. This authorization expires one year after it is signed.

I hold the above named institution harmless from any and all damages which might result to, myself, my relatives or heirs from the use of this information being disclosed to the person, company or agency specified above.

THE FOLLOWING APPLIES ONLY TO DRUG AND/OR ALCOHOL ABUSE/TREATMENT INFORMATION RECORDS Prohibition on Re disclosure: this information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit you from making 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.

_____ Initials

AUTHORIZATION FOR RELEASE OF ACCOUNT INFORMATION (ARA)

THE FOLLOWING APPLIES ONLY TO HUMAN IMMUNODEFICIENCY TESTING Prohibition on Re disclosure: this information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof. This authorization also includes the authority to copy and inspect any and all such records.

A copy of this authorization may be used in place of and with the same force and effect as the original.

_____ _____

Name Signature

Sworn to me before me this ___ day of _____, 20__.

_____

Notary Public, State of Georgia at Large

_____ Initials