Certification and Release of Information

A. By signing the confirmation below, I certify to the Board that:

1. I have provided truthful, complete and accurate information on this application; and
2. I have exhausted all other insurance and governmental funding sources before applying to LWL.

B. I represent and assure the LWL that, if I am granted funds, I will:

1. Use the funds for the purpose stated in this application; and
2. Promptly report in writing to LWL any change in the availability of insurance and governmental funding sources that may affect my eligibility for funds.

C. I understand and acknowledge that:

1. LWL has the right to rely on the information contained in this application or any subsequent amendments; and
2. The LWL has the right to withdraw or modify any disbursement in the event that:
    - The information contained in this application or any subsequent amendment should at any time be determined to be false, incomplete, inaccurate, or misleading; or
    - The funds are used for a purpose other than that stated in this application; or
    - The LWL becomes aware of any change in my status or circumstances that may affect my eligibility; and
3. The LWL's determination may affect not only continued eligibility but also affect future eligibility for qualification; and
4. It is my responsibility to determine if the receipt of funds legally impacts other benefits that I may receive.

D. Release of Information

1. Any physician, medical practitioner, hospital clinic or other medical or medically related facility, insurance company, Third Party Administrator, the Medical Information Bureau or any similar organization, institution or person, any employer, group plan holder or certificate holder.
2. If the record released contains information relating to HIV test results, AIDS, alcohol abuse or mental health care, enough of this information is to be

released to accomplish the purposes for which the information is requested and to the extent permitted by law.

3. I understand that the information released to LWL may be used to process my application for disbursement funds and may be given to any person or entity carrying out a function for, on behalf of or in conjunction with LWL.
4. This information may also be re-disclosed as otherwise specifically required or permitted by law.
5. This authorization shall remain in effect until revoked by me in writing.

I may obtain a photocopy of this authorization upon request.

I authorize LWL to exchange relevant information with other organizations in order to process the enclosed application completely and efficiently. I understand that this information may be shared in order to better provide the services I have requested.

I certify that the information I have provided on this application to be true to the best of my ability. I understand that falsifying information or providing false certification(s) may be subject to civil or criminal penalties as provided by Georgia state law.

Signature of person applying to Lives Without Limits

_____

Date

LWL does not consider itself a "covered entity" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)