Authorization for Use or Disclose of Protected Health Information (PHI)

I, _____, the undersigned, hereby voluntarily authorize the disclosure of personal health information from my health record needed for my care and other important purposes.

I would like to specifically identify the following individuals that the Assisted Living Facility can disclose this information to:

1. _____
2. _____
3. _____

The purpose or need for this disclosure is to

- Further medical care
- Personal use
- Attorney
- Insurance
- Research
- Other, please specify_____

My presence:

__☐ Is required
__☒ Is not required when information is released to the above individuals

If you have authorized us to discuss confidential information, specify the period during which we may communicate with the person(s) listed above, by checking the appropriate box below:

__☒ I authorize ongoing communication unless I revoke this consent
__☐ I authorize communication only until _____ (specify date)

I also authorize those providing me with treatment to share personal health information to the Assisted Living Facility:

I understand that my personal information may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I further understand that I may revoke this authorization in writing and that treatment or eligibility for my care is conditioned to on my providing this authorization except if such care is research related or provided solely for the purpose of creating protected health information for disclosure to a third party

_____
Resident Name (printed)

_____
Resident/POA Signature

_____
Date