TWO-WAY AUTHORIZATION

FOR THE USE OR DISCLOSURE OF INFORMATION

Ellen Rice Rest Home, Inc.

CLIENT NAME: _____ **DATE OF BIRTH:** ___/ ____/ _____ **DATE:** ___ / ____/ _____
By signing this Authorization for the Use or Disclosure of Information, I authorize employees of ELLEN RICE REST HOME **to receive and release information from or to the person or organization named below, electronically, verbally or in writing:**

Organization/Individual _____ Attention: _____

Address:_____(Fax#)_____(Phone#) _____

INFORMATION TO BE USED/DISCLOSED

☐ The entire clinical/medical record (all information) ☐ Only services **from:** _____ **to:** _____

☐ All information in my clinical/medical record related to services provided to me by ELLEN RICE REST HOME, INC.

☐ Other(describe as specifically as possible):_____

INFORMATION REQUIRING SPECIFIC AUTHORIZATION

I consent to disclosure of my confidential health care information regarding alcohol and drug abuse records, HIV/AIDS and/or Genetic Testing to those persons/ agencies named above, by initialing the boxes below. I understand that if I do not initial a category below, the information related to that category will not be released.

_____Alcohol or Drug Abuse _____ HIV/AIDS _____ Genetic Information

I understand that if I do not initial a category above, the information related to that category will not be released.

PURPOSE(S) OF USE/DISCLOSURE

___ Continuing care/treatment ____ My personal records ____ Sharing with other providers/coordination of care ___ Legal matter

Information may be released in the following format(s): __ Verbally ___ Paper Documents ___Mail __ Fax __ Electronic Format __ Email ____ Phone

AUTHORIZATION

I have read and understand the terms of this Authorization and agree that:

1. With my signature, the protected health information ("PHI") specified above will be released to the recipient designated above.
2. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
3. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain rest home care from ELLEN RICE REST HOME, INC. except when: (i) my refusal may limit ability to provide safe and effective care; (ii) I am receiving research-related treatment, or (iii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these excepts apply, my refusal to sign an authorization may result in my not obtaining resident care from ELLEN RICE REST HOME, INC.
4. 4. I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by ELLEN RICE REST HOME, INC. prior to receipt of my written notice of revocation. I may revoke this authorization in writing to ELLEN RICE REST HOME, INC.

This authorization will automatically expire one (1) year from the date it is signed, unless otherwise indicated here: _____

X_____ X_____
Signature of Client or Legal Representative Relationship to Client

Print Name:_____ Date:___ / ____/ _____