THE CARE TEAM
Home Health & Hospice

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ **Date of Birth**: _____

Patient Address: _____**Date:**_____

Authorization Agreement

The person making this authorization request is (check one): ☐ Individual (Patient) ☐ Legal Representative

- I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules (HIPAA).
- I understand that I may revoke this authorization at any time by notifying The Care Team in writing. If I choose to do so, my request to revoke will not apply to information that has already been released in response to this authorization.
- I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment or eligibility for care.
- Unless I specify differently, this authorization will expire one year from the date of my signature. Specified expiration date: _____

I, (Patient/Legal Representative Name) _____authorize The Care Team to use or disclose my health information as described below.

Type of information to be used or disclosed:

☐ Entire medical record	☐ Laboratory Reports	☐ Billing Statements
☐ OASIS assessment(s)	☐ Plans of Care	☐ SNF documents
☐ Skilled nurse visit notes	☐ Physician Orders	☐ Hospital documents
☐ Therapy evaluations	☐ Face to Face Documentation	☐ X-ray/Imaging Reports
☐ Therapy visit notes	☐ Discharge Summaries	☐ Physician documentation
☐ Social work evaluations	☐ Other: _____	
☐ Social work visit notes	☐ Other: _____	

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS related treatment

☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)

☐ Other: _____

Recipient of Information – The information may be used by, or disclosed to, the following individual(s) or organization(s):

☐ Name and Address:

☐ Name and Address:

For the purpose of: _____

Signature of Patient/Legal Representative: _____Date: _____

Printed Name: _____

Legal Representative relationship to patient: _____