AUTHORIZATION FORM

Policy #20075

I authorize the use/disclosure of health information about me as described below.

1. Person(s) or class of persons authorized to use/disclose the information:

   _____

   _____

2. Person(s) or class of persons authorized to receive the information:

   _____

   _____

3. Description of information that may be used/disclosed:

   _____

   _____

4. The information will be used/disclosed for the following purposes: **(Note: "at the request of the individual" is sufficient, when an individual initiates authorization and does not, or elects not to, provide a statement of purpose.)**

   _____

   _____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

6. *[If applicable]* I understand that _____ will receive compensation for its use/disclosure of the information. **(Note: this item is not required if the disclosure is requested by the resident.)**

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

8. I understand that I may revoke this authorization in writing at any time by signing the Revocation of Authorization except to the extent that action has been taken in reliance on this authorization. This authorization expires _____ [*insert applicable date or event]*.

_____
Resident's Name

_____ _____
Signature of Resident or Representative Date

_____ _____
Name of Personal Representative (if applicable) Relationship to Resident

If signed by a Personal Representative, provide a description of the personal representative's authority to act for the individual. Attach supporting documentation, if applicable.

_____

_____

_____

REVOCATION OF AUTHORIZATION

I hereby revoke the above authorization.

_____ _____
Signature of Resident or Representative Date

_____ _____
Name of Personal Representative (if applicable) Relationship to Resident