

ON SITE FOR SENIORS, INC

6848 N Govt Way, Suite 114-5 Dalton Gardens, ID 83815

TEL: (208) 967-4771

AUTHORIZATION TO OBTAIN AND/OR DISCLOSE HEALTH INFORMATION

I, (name of patient): _____ Date of Birth: _____ SSN: _____

Address: _____ authorize On Site for Seniors, Inc. to:

_____ Release Information to: _____ Obtain Information from:

Name of Physician or Recipient: _____ Phone: _____

Address: _____ State: _____ Zip Code: _____

The information is being released/obtained for the following reason(s):

(A statement "at the request of the individual" is sufficient if the patient signs this authorization and does not wish to give a specific reason)

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records:

_____ Most Recent two-year history _____ Laboratory and/or Pathology Reports Only
_____ Problem List/Medication List/Allergy List _____ Entire medical records
_____ Other: _____

The following items **must** be initialed to be included in the use or disclosure of other health information:

_____ HIV/AIDS related health information and/or records
_____ Sexually Transmitted Disease Information and/or records
_____ Mental Health Information and/or records
_____ Genetic testing information and/or records
_____ Drug/Alcohol diagnosis, treatment and/or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

- 1) I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).
- 2) Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to On Site for Seniors, Inc. **Unless revoked earlier, this authorization will expire 6 months from the date of signing or upon [insert applicable date or event of expiration]:** _____
- 3) I also understand that, if the person or entity receiving this 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 these regulations. However, the recipient maybe prohibited from disclosing my health information under other applicable state or federal law and regulations. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524.
- 4) I understand that depending on the size of the records, copying/delivery fee may apply.

Signature of Patient or Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Guardian to Individual