LifeCare
HOSPICE

AUTHORIZATION FORM

A separate authorization must be used if the authorization is for psychotherapy notes.

Patient Name: _____ Birth Date: _____/_____/_____
Month Day Year

Address: _____

Telephone Numbers: Home: _____ Work: _____

I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. I have signed this form voluntarily in order to document my wishes regarding the use and/or disclosure of the health information described below in Section 1 of this form.

1. I Authorize the Following Health Information to be Used and/or Disclosed.
(Specify and provide meaningful description, including dates.)

- ☐ Name
- ☐ Address
- ☐ Phone Number
- ☐ Social Security Number
- ☐ Diagnosis
- ☐ Disease Information
- ☐ Dates of Care/Services
- ☐ Other _____

2. I Authorize the Following Persons/Organizations to Use and/or Disclose My Health Information.

- ☐ LifeCare Hospice
- ☐ Other _____

3. I Authorize the Following Persons/Organizations to Receive and/or Use My Health Information.

- ☐ Department of Job and Family Services
- ☐ Lifeline / Medic Alert
- ☐ Meals on Wheels
- ☐ LifeCare Hospice
- ☐ Other _____
- ☐ Aurora Ministries, providers of The Bible on tape

4. I Authorize My Health Information to Be Used and/or Disclosed for the Following Purpose(s).

- ☐ Coordination of Services
- ☐ Help in Securing _____ Services
  Type of service financial, community service, emergency assistance
- ☐ At the request of the organization or individual _____
  organization or name of person

5. My Right to Revoke This Authorization.

I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form I may contact the Hospice Privacy Officer. I am aware that my revocation will not be effective if (1) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (2) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

6. Redisclosure of My Health Information. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.

7. Disclosure of Direct or Indirect Remuneration Received By Any Person or Organization Authorized to Use and/or Disclose My Health Information. I understand that:

X No one ☐ LifeCare Hospice

☐ _____ (person/organization name) will be receiving direct or indirect remuneration (payment) in connection with the use and/or disclosure of my health information. The amount and/or nature of the remuneration is as follows:

X N/A, Not Applicable ☐ $ _____ (amount) ☐ _____ (nature of remuneration)

8. Expiration of Authorization (Must be completed)

This authorization will be effective until the following date or event: _____

If Patient is unable to sign, complete this information:

Patient is unable to sign because: _____

Name of Personal Representative: _____

Relationship to Patient: _____

Authority of Personal Representative (e.g., health care power of attorney, guardian, other statutory authorization):

_____

Address: _____

_____

Telephone Numbers: Home: _____ Work: _____ Cell _____

E-mail: _____

____ A copy has been set to the person who signed this authorization

_____ _____

Signature or Signature of Personal Representative Date