Facility Name: ____

Address: ____

____

Phone: ____

Fax: ____

MEDICAL INFORMATION RELEASE

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Protected Health Information (PHI) may be required and/or requested for a resident of this facility for the purposes of meeting health care needs and/or treatment.

Under HIPAA, each individual must authorize the release of PHI, including their personal medical information and PHI (such as medical history, billing information), to any individual and/or entity. Such entities may include, but is not limited to, Physicians, Psychiatrists, ARNP's, Testing Facilities, Home Health Agencies, and other providers.

I, ____, give authorization to release necessary PHI to this facility. Further, I give authorization to this facility to release my PHI if and when necessary to allow for medical and/or related treatment. Every reasonable effort will be made to prevent the release of PHI by this facility.

_______________________________________ ______________________

Resident Signature Date

_______________________________________ ______________________

Guardian / POA Signature Date

_______________________________________ ______________________

Facility Administrator Date