

# Hospice & Palliative Care of Greater Wayne County

Patient Identification Number: \_\_\_\_\_

## PATIENT AUTHORIZATION FORM

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

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MO / DA / YR

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.)

- |   |   |
|---|---|
| <input type="checkbox"/> Name                   | <input type="checkbox"/> Diagnosis              |
| <input type="checkbox"/> Address                | <input type="checkbox"/> Disease Information    |
| <input type="checkbox"/> Phone Number           | <input type="checkbox"/> Dates of Care/Services |
| <input type="checkbox"/> Social Security Number | <input type="checkbox"/> Other _____            |

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

- Hospice & Palliative Care of Greater Wayne County
- Other \_\_\_\_\_

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

- |  |   |
|--|---|
| <input type="checkbox"/> Department of Job and Family Services | <input type="checkbox"/> Hospice & Palliative Care of Greater Wayne County        |
| <input type="checkbox"/> Lifeline / Medic Alert                | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Meals on Wheels                       | <input type="checkbox"/> Aurora Ministries, providers of <u>The Bible</u> 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

