

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

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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

No one Hospice & Palliative Care of Greater Wayne County _____
(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:

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 sent to the person who signed this authorization

Patient Signature or Signature of Personal Representative

____/____/____
Date