ON SITE FOR SENIORS, INC

PO BOX 238, HAYDEN, ID 83835
TEL: (208) 967-4771 FAX (208)-683-8101

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 _____ FAX # _____

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
_____ Problem List/Medication List/Allergy List
_____ Other: _____
_____ Laboratory and/or Pathology Reports Only
_____ Entire medical records

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.
PLEASE SELECT ONE:

_____ Paper copy for pick up - ____Paper copy for mailing ___ Digital copy over patient portal

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print Name of Legal Representative (if applicable) Relationship of Legal Guardian to Individual