Authorization for Release

Authorization for Release of Information

Regarding _____ Date of Birth: _____

Authorization is hereby granted to: _____

_____

_____

(Physicians Name, Address & Phone)

To release to: Location: _____

Address: _____

City, State Zip: _____

Phone: _____

Fax: _____

The following specified information from the medical records compiled during my stay from _____ to _____ is to be disclosed:

_____ Diagnosis

_____ Discharge Summary and/or Transfer Record

_____ Last Laboratory and/or X-ray Data

_____ Negotiated Service Agreement

_____ signed medication orders

_____ POST

_____ Dietary Guidelines

_____ History & Physical

Additional information: _____

_____

_____

For the purpose of: _____ Placement in Assisted Living Facility _____

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose (s) this consent will automatically expire without my expressed revocation. I do not authorize further release of information or any other party.

_____ _____

Signature of Witness Signature of Resident (see note below*)

_____ _____

Date Signed by Witness Relationship to Resident

* Authorizations to be signed by the RESIDENT, or by the next of kin, legal guardian or authorized representative when resident's physically or mentally unable.