RELEASE OF MEDICAL INFORMATION

AGENCY NAME & ADDRESS

PLEASE COMPLETE FORM IN ENTIRETY. Items that are not checked or left blank are assumed non-applicable or not authorize for release. This release is not valid unless signed and dated by the patient or the legal representative. This release may be revoked at any time by the patient or legal representative.

I hereby authorize the disclosure of my individual healthcare record to _____ Hospice for the purpose of physician review, for providing supporting documentation of my Hospice diagnosis, and for the coordination of my healthcare. I have received information regarding HIPPA and The Privacy Act and understand my rights regarding my healthcare record. This for is valid for one year from date of signature.

PATIENT NAME: _____

ADDRESS _____CITY_____STATE_____

SS#:_____ DATE OF BIRTH:_____

INFORMATION REQUESTED: ***Please check all that apply***

___Physician Order	**___ Lab results**	**___ Therapy Notes**	**___Dietary notes/swallowing studies**
___History & Physical	**___Radiology Reports**	**___Pathology Reports**	**___Hospice certification/re-certification**
___Physician Progress Notes	**___Cardiac Diagnostics**	**___Nuclear Scan Reports**	**___ Hospice Plan of Care**
___Physician Consults	**___Lung Function Tests**	**___Medication Profile**	**___ Face to Face Visit**

__OTHER:_____

I am requesting the following healthcare records for period ____/____/_____ to Present

List facilities/physicians information is requested from: 1._____

2. _____ 3. _____

RESTRICTION OF DISCLOSED MEDICAL INFORMATION

□ **I DO NOT HAVE ANY RESTRICTIONS ON MY INFORMATION**

□ **I REQUEST THE FOLLOWING USE/RESTRICTIONS OF MY HEALTHCARE RECORD:** (Specific treatments and dates of treatments that may not be disclosed**)**

_____

_____

□ **I REQUEST THAT NO INFORMATION REGARDING MY HEALTHCARE BE RELEASED TO THE FOLLOWING PERSON(S):**

_____

_____

PATIENT/LEGAL REPRESENTATIVE SIGNATURE: _____ DATE:_____

HOSPICE REPRESENTATIVE SIGNATURE: _____ DATE:_____