Protected Health Information Release Authorization

Resident Name: ______________________________ Date of Birth: ________________________

This will authorize ____ to disclose my
(Name of Entity)

protected health information for the following purpose:

Name of person(s)/entity **releasing** information:

____
Name
____
Street Address
____
City, State, Zip Code
____
Phone Number Fax Number

Name of entity **receiving** information:

Nadeau Senior Care Services, LLC
d.b.a. Carriage Hill Assisted Living
306 Knox Marsh Road
Madbury, NH 03823
Phone: (603) 343-4475
Fax: (603) 343-5872

Information To Be Disclosed

Complete medical record (This may include, as applicable, information related to mental health, drug and alcohol treatment, genetic testing, HIC/AIDS, and psychotherapy notes).

OR

Records from the following dates: __________________ to ______________________.

OR

I only want the following parts of my medical record to be disclosed as listed below:

____

____

The choice I made above contains certain information I do not want disclosed as listed below:

____

____

Resident Name: ____________________________________ Date of Birth:___________

- I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. Carriage Hill Assisted Living, LLC will not refuse residency based on my refusal to sign the Authorization.

- You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. If you wish to revoke this Authorization, please send your written request to Carriage Hill Assisted Living, LLC at 306 Knox Marsh Road, Madbury, NH 03823.

- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may no longer protect it.

- I understand that I have the right to inspect or receive a copy of the information I am consenting to release.

- Once this Authorization has expired, we will no longer use or disclose your health information for the purpose listed in this Authorization unless you sign a new form. This Authorization expires:

  a. On the following date: _____/_____/_____
  b. When the following event occurs: ____
  c. If neither (a) nor (b) is completed above, this Authorization will expire 12 months from the date this form is signed.

_________________________________ _________________________________ __________

Printed Name | Signature of Resident or Legal Representative (**Legal Handwritten Signature Only Accepted**) | Date

____

Authority or Relationship of Representative (*Attach copy of documentation of authority*)

TO RECIPIENT OF THIS AUTHORIZATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. If the information is drug or alcohol abuse treatment information covered by 42 CFR Part 2, Federal Law prohibits you from making any further disclosures of this information without the specific written authorization of the individual to which it pertains.

AUTHORITY: This form is designed to comply with CFR 45 Sec. 164.508.

A copy of this Authorization must be provided to this patient.