PROVIDENCE
Adult Day Health
6018 N. Astor
Spokane, WA 99208
Phone: 509-482-2475
Fax: 509-482-2490

AUTHORIZATION TO RELEASE AND RECEIVE INFORMATION

I,_____(Participant Name), DOB_____

authorize 'PROVIDENCE ADULT DAY HEALTH' to Release and Receive the following information:

Medical history, diagnosis, medications, treatments
Care plan,

To/FROM _____

_____

RIGHTS OF THE PARTICIPANT:

- The information listed here above is to be released for only the stated purpose. Any other use is forbidden.
- I may inspect and receive a copy (nominal fees may be charged)
- This authorization is voluntary and I may refuse to sign the authorization form. I may not be refused treatment or payment if I refuse to sign this form.
- This authorization is valid until my relationship with the Providence Adult Day Health is discontinued. I understand that I may also revoke authorization at any time by contacting the Case Manager. The revocation must be in writing, dated and signed by the client or legal representative (DPOA).
- If I am providing authorization for marketing purposes, I understand that Providence Adult Day Health may receive payment from a business associate as a result of using or disclosing my information.
- I may receive a copy of this authorization if requested.
- Information disclosed as a result of this authorization may be re-disclosed by the party listed above as the recipient, and may no longer be protected by state and federal privacy rules.

I understand that I can revoke this authorization at any time with written notification. I am also aware that this information may be subject to re-disclosure by the recipient of this information and may no longer be protected.

_____ _____

Signature of Participant/Responsible Party Date