

Providence Seward Mountain Haven

P.O. Box 430 / 2203 Oak Street
Seward, AK 99664
Tel: (907) 224-2900 Fax: (907) 224-5250
Social Services Tel: (907)224-2988

Authorization to Release Financial Information

Elder Name: _____

Date of Birth: _____

I authorize the Division of Public Assistance, the Social Security Administration, the Veterans Administration, and/or my insurance company(s) to discuss with Providence Seward Mountain Haven my eligibility and benefits as they pertain to my admission and continuing stay at Providence Seward Mountain Haven.

THE INFORMATION DISCLOSED TO YOU INCLUDES INFORMATION FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY FEDERAL LAW. FEDERAL REGULATIONS (42 CFR PART 2) PROHIBITS YOU FROM MAKING FURTHER DISCLOSURE OF IT WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT FOR THIS PURPOSE.

This release/exchange will expire six months after my discharge from Providence Seward Mountain Haven. This release/exchange may be revoked at any time by written notification.

A photocopy of this release form shall be as valid as the original.

Signature of Elder

Name of Resident

Signature of Legal Representative*

Name of Legal Representative

*Legal Representative: I am the legal representative; a copy of my appointment as _____ is on file with Providence Seward Mountain Haven.

WITNESS:

Signature of Witness

Date