AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective Date: April 14, 2003

Section A: Must be completed for all Authorizations

By signing this Authorization, I hereby authorize and permit the Corporation to use and/or disclosure my Protected Health Information as that term is defined at 45 C.F.R. '164.501 for the limited purpose(s), and in the limited manner described in this Authorization. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name: ________________________ **Patient Signature:** ________________________

Patient Address: ___________________________ **Patient Birthdate:**________________________

____

Persons/organizations authorized to use or disclose the information: **Senior Resource Alliance / Area Agency on Aging.**

Persons/organizations authorized to receive the client's personal information (list names):____

____

____

____

Specific description of information, including date(s), to be used and/or disclosed about client:

STATEWIDE MEDICAID MANAGED CARE AND LONG TERM CARE ENROLLMENT ASSISTANCE

____

____

Section B: Must be completed only if Senior Resource Alliance (SRA) /Area Agency on Aging requested the Authorization.

1. The Patient must complete the following:

a. What is the purpose of the use or disclosure? (Check one)

i. At the client's or the client's representative's request or direction.

ii. For marketing.

iii. For research.

iv. To provide information to the Patient's family members or other individuals who will provide care for the Patient: (list names of all individuals)

v. Other (describe): ____.

b. Will the Corporation receive financial or in-kind compensation, directly or indirectly, in exchange for using or disclosing the Protected Health Information described above?

Yes: _____ No: X

2. The Patient or the Patient Representative must read and initial the following statements:

a. I understand that my health care and the payment for my health care will not be affected if I do not sign this Authorization. Initials: _____

b. I understand that I may see and copy the information described on this Authorization if I ask for it, and that I may have a copy of this Authorization after I sign it. Initials: _____

c. I understand the recipient of the information may disclose the information. Initials: _____

Section C: Must be completed for all Authorizations

The Patient or the Patient representative must read and initial the following statements:

1. I understand that this Authorization will expire: (Check one)

i. On _ _/_ _/_ _ _ _ (DD/MM/YYYY)
Initials: _____

ii. No expiration (permitted only for Authorizations used to create or maintain research databases or repositories). Initials: _____

iii. When the following event occurs: Initials: _____

2. I understand that I may revoke this Authorization at any time by notifying the Corporation in writing, but if I do, it will not have any affect on any actions the Corporation took before it received the revocation. Initials: _____

____
Signature of Patient or Patient Representative **Date:** ___________________________
(Form MUST be completed before signing)

Printed name of Patient Representative:________________________________

Relationship to the Patient:____

Reason Authorization signed by Patient Representative: ***(Check one)***

Minor: _____

Incompetent: _____

Other *(Explain)*:____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

If this Authorization authorizes use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other Protected Health Information. A separate Authorization is needed for any other use and/or disclosure.

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