HIPAA

Cedar Hill Continuing Care Community

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(Individual/Resident): _____

_____ _____ ( )_____

Previous Names *Birth Date* *Phone*

_____ _____

Street Address *City, State, Zip*

AUTHORIZES: DISCLOSURE OR PROTECTED HEALTH INFORMATION TO:

_____ _____

Individual(s)/agency/organization making disclosure *Individual(s)/agency/organization receiving disclosure*

_____ _____

Street Address *Street Address*

_____ _____

City, State, Zip *City, State, Zip*

INFORMATION TO BE USED &/OR DISCLOSED:

The following is a specific description of health information I authorize to be used and/or disclosed:

_____

_____

_____

Please release records pertaining to:
(Check all that apply)

_____ Mental Health _____ Alcohol & Drug Abuse _____ HIV test Results
_____ Other (Specify) _____

For the Following Date(s): From _____ to _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

_____ Further Medical Care _____ Coordinating Care for Dependent/Spouse _____ Claims Resolution
_____ Insurance Eligibility/Benefits _____ Other (Specify): _____

HIPAA

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization: I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization: I understand that I am under no obligation to sign this form and that CEDAR HILL CONTINUING CARE COMMUNITY may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this.

Right to Withdraw This Authorization: I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to CEDAR HILL CONTINUING CARE COMMUNITY. I am aware that my withdrawal will not be effective until received by CEDAR HILL CONTINUING CARE COMMUNITY and will not be effective regarding the uses and/or disclosures of my health information that CEDAR HILL CONTINUING CARE COMMUNITY has made prior to receipt of my withdrawal statement. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Right to Inspect of Copy Health Information to Be Used or Disclosed: I understand that I have the right to inspect or copy (provided at a reasonable fee) the health information I have authorized to be used or discloses by authorization form. I may arrange to inspect my health information or obtain copies or my health information by contacting CEDAR HILL CONTINUING CARE COMMUNITY MEDICAL RECORDS DEPARTMENT.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE: This authorization is good until (indicated date or event) _____.
By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE PATIENT/LEFAL REP: _____ **DATE:** _____
(IF SIGNED BY OTHER INDIVIDUAL STATE RELATIONSHIP WITH SIGNATURE)