INTEGRITY
HOME CARE + HOSPICE

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

All sections of this authorization form MUST be completed

Patient Name:_____ Medical Record Number:_____

Date of Birth:_____/_____/_____ Social Security Number:_____

I authorize Integrity Home Care to (DISCLOSE/RECEIVE) the above named individual's health information as described below.

The type of information to be used or disclosed is as follows:

□ Care Plan
□ Visit/Nursing Notes
□ Physician Orders
□ Medication Records
□ Discharge Summary
□ Other (Specify):_____
□ Billing Records (Specify)
□ Date Range: _____ to _____

The information identified above may **(DISCLOSED BY OR DISCLOSED TO)** the following individual or organization:

Name:_____

Address:_____

City/State _____Zip Code: _____

How information is to be received (if not marked paper is default):

☐US Mail-paper format ☐Fax:_____
☐ E-mail- Secured _____

This information for which I am authorizing disclosure will be used for the following purpose(s):

□ My personal records
□ Continuing Medical Care
□ Social Security/Disability
□ Legal Purposes
□ Insurance
□ Other: _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Integrity Home Care staff. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will expire within *6 months* from the date on which it was signed. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand that 191.227, RSMo, authorizes a healthcare provider to charge a fee per page for the cost of supplies plus labor, and that records will be released upon the receipt of payment.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

_____ _____
Signature of patient or legal representative Date

Printed name of authorized representative:_____ Relationship to client:_____

_____ _____
Signature of witness Date

If signed by legal representative, supporting legal documentation must accompany this authorization form