AUTHORIZATION TO RELEASE MY PERSONAL HEALTH INFORMATION

Dear BAYADA Home Health Care:

Re: Client Name: _____ Client #: _____

Please release the following information (describe type of information and dates of services, if applicable):

Basic medial diagnosis, care coverage issues, and all other information used for advocacy purposes.

To:

Name: Hearts for Home Care

Address: 50 S 16th St, Suite 1700

City: Philadelphia State: PA Zip Code: 19102

Telephone: _____

For the following reason/purpose:

To raise awareness of home care issues through public affairs avenues: i.e. legislative home visit

I understand that:

1. This authorization is voluntary and is not required for me to continue receiving treatment from BAYADA.
2. This release specifically covers any confidential information pertaining to HIV status, mental health treatment and substance abuse records. I am aware that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this information cannot be released without my consent and I have the right to inspect the information that is released.
3. I have the right to inspect the information to be released and to refuse to authorize the release following my inspection.
4. I may revoke this authorization in writing at any time by notifying BAYADA; but until BAYADA receives my written revocation, they may continue to release information about me to the person or organization listed above.
5. This authorization will expire on _____ or one year after the date of my signature, whichever is shorter.
6. There is a possibility that the information being disclosed as part of this authorization could be subjected to re-disclosure by the person receiving the information and no longer protected under HIPAA.

_____ _____

Signature of Client or Client's Representative Date

If client is unable to sign this form, please complete the following:

Printed Name of Client's Representative: _____

Relationship to Client: _____