AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, hereby authorize:

_____

(Name & address of facility that is to release the information)

To release confidential health care information to:

_____

(Name & address of person/facility the information is to be sent)

Regarding Resident/Patient's Name:_____

Date of Birth:_____

The following information is to be released (be specific; include time frames):

[ ] Physician's History & Physical [ ] Discharge Summary
[ ] Nurse's Notes (time frame):_____
[ ] Physician's Progress Notes (time frame):_____
[ ] Medication/Treatment Administration Records (time frame):_____
[ ] Physician's Orders (time frame):_____
[ ] Therapy Documentation
[ ] Other:_____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. This authorization is automatically void (90) ninety days from the date of signature below.

_____ _____
Resident (or if incapacitated, legal representative) Date

_____ _____
Witness Signature Date