## AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

hereby authorize				
	NAME OF DISCLOSING PARTY			
	ADDRESS			assertion on the contract of t
	CITY STATE	ZIP	***************************************	
disclose to		Taylor Elder Care	Management	
	NAME OF RECEIVING PARTY 484 Johnson Street			
	ADDRESS	Sebastopol, CA 95	472	**************************************
	CITY STATE	229	HAT BEET TO THE PERSON OF THE	and the second s
cords and information	on pertaining to			
AME OF PATIENT (LIST OT				
AME OF PATIENT (LIST (J)	NER NAMES USED)	MEDICAL RECORD NU	MBER DATE OF BIR	TE
ODRESS			TELEPHONE NUI	MER
URATION:	This authorization shall become effective immediately and shall remain in effect until  DATE  Or for one year from the date of signature.			
EVOCATION:	This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon this authorization.			
	and the second s	marin min.c. a a sa	n inis authorization.	
EDISCLOSURE:	I understand that the requeste		or disclose the health in	nformation unless another authorizated by law.
	I understand that the requeste obtained from me or unless s	r may not lawfully further use	or disclose the health in ally required or permit	aformation unless another authorizated by law.
EDISCLOSURE: PECIFY: ECORDS:	I understand that the requeste obtained from me or unless s	or may not lawfully further use such use or disclosure is specific pecify which type of information	or disclose the health in ally required or permit	ted by law.
PECIFY:	I understand that the requeste obtained from me or unless s Check the box and initial to s	r may not lawfully further use uch use or disclosure is specific pecify which type of information	or disclose the health is sally required or permit on is to be disclosed.	ted by law.
PECIFY:	I understand that the requeste obtained from me or unless s Check the box and initial to s	r may not lawfully further use uch use or disclosure is specific pecify which type of information on	or disclose the health in cally required or permit on is to be disclosed. PSYCHIATRIC INFO	RMATION  DATE
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This authorization is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) for authorizations for uses and disclosures.

## AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Neither treatment, pay	yment, enrollment, nor eligibility of benefits will be conditioned on my providing or refusing to provide this authorization.
I hereby authorize	Leave this section blank
	ADDRESS
	CETY STATE ZIP
to disclose to	Taylor Elder Care Management
	NAME OF RECEIVING PARTY 484 Johnson Street
	ADDRESS Sebastopol, CA 95472
	CITY STATE ZIP
records and information	
NAME OF PATIENT (LIST OF	NER NAMES USED)  MEDICAL RECORD NUMBER  DATE OF RETE
ADDRESS	ca 95655 THEE MIMBER
DURATION:	This authorization shall become effective immediately and shall remain in effect intil or for one year from the date of signature.
REVOCATION:	This authorization is also subject to written revocation by the dersigned carry to the ween now and the disclosure of information by the disclosing party. My written avoid for will be effective upon receipt, but will not be effective to the extent that the requestor or others have a controlled upon the outhors.
REDISCLOSURE:	I understand that the conster may not lawful afurther see or discusse the health information unless another authorization is a from no or unless such use or disclosion is specifically record or permitted by law.
SPECIFY:	Check the box are mittal to saify which type of information is to be disclosed.
RECORDS:	MEDI AL INFORMATION PSYCHIATRIC INFORMATION
	Patrice to one DATE   DOI!
	☐ DRUG/ALCOHOL INFORMATION ☐ RESULTS OF AN HIV BLOOD TEST
	SIGNATURE DATE DATE
	☐ OTHER HEALTH INFORMATION(specify below)
Specify the records to	
	All records, no limitations
Skills	tient outpatient, emergency care,
agen	dor ossisted facilities insurance
J	
The requester may use	the health information authorized on this form for the following purposes only:
and c	condination.
Date: 1/1/2	OII Signature: Ferfricia Jones Durable Hower
	of Attorney for Health care