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

Neither treatment, payment, enrollment, nor eligibility of benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize

NAME OF DISCLOSING PARTY

ADDRESS

CITY STATE ZIP

to disclose to **Taylor Elder Care Management**

NAME OF RECEIVING PARTY

ADDRESS **484 Johnson Street**

CITY STATE ZIP **Sebastopol, CA 95472**

records and information pertaining to

NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

ADDRESS TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (DATE) or for one year from the date of signature.

REVOCATION: 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.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of information is to be disclosed.

RECORDS:

☐ MEDICAL INFORMATION _____ (INITIAL)

☐ PSYCHIATRIC INFORMATION

SIGNATURE DATE

☐ DRUG/ALCOHOL INFORMATION

SIGNATURE DATE

☐ RESULTS OF AN HIV BLOOD TEST

SIGNATURE DATE

☐ OTHER HEALTH INFORMATION _____ (specify below)

Specify the records to be disclosed:

The requester may use the health information authorized on this form for the following purposes only: _____

Date: _____ Signature: _____

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, payment, enrollment, nor eligibility of benefits will be conditioned on my providing or refusing to provide this authorization.

I hereby authorize Leave this section blank

NAME OF DISCLOSING PARTY

ADDRESS

CITY STATE ZIP

to disclose to Taylor Elder Care Management

NAME OF RECEIVING PARTY

ADDRESS 484 Johnson Street

CITY STATE ZIP Sebastopol, CA 95472

records and information pertaining to

Sam L. Jones | N/A | 1/1/2011

NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

ADDRESS 111 Sonoma Ave. Sonoma, CA 95555 TELEPHONE NUMBER 707.777.7772

DURATION: This authorization shall become effective immediately and shall remain in effect until no limit DATE or for one year from the date of signature.

REVOCATION: 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.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of information is to be disclosed.

RECORDS:

☑ MEDICAL INFORMATION PJ INITIAL

☑ PSYCHIATRIC INFORMATION Patricia Jones 1/1/2011 SIGNATURE DATE

☐ DRUG/ALCOHOL INFORMATION Patricia Jones 1/1/2011 SIGNATURE DATE

☐ RESULTS OF AN HIV BLOOD TEST SIGNATURE DATE

☐ OTHER HEALTH INFORMATION _____ (specify below)

Specify the records to be disclosed: All records, no limitations

Inpatient, outpatient, emergency care, skilled or assisted facilities, insurance agencies, professional counselors

The requester may use the health information authorized on this form for the following purposes only: Case management advocacy and coordination.

Date: 1/1/2011 Signature: Patricia Jones Durable Power of Attorney for Healthcare

This authorization is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) for authorizations for uses and disclosures.