Hospice OF MARION COUNTY, INC.

P. O. Box 4860 Ocala, FL 34478-4860 (352) 873-7400

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ Hospice #:_____

Social Security #:_____-_____-_____ Date of Birth:_____/_____/_____

I hereby authorize Hospice of Marion County, Inc.:

☐ to **obtain** medical information from: ☐ to **release** medical information to:

Name:_____ Address/Phone:_____

Name:_____ Address/Phone:_____

Name:_____ Address/Phone:_____

_____ I authorize Hospice of Marion County, Inc., to provide updates on my care to the above mentioned physician(s). (Initials)

Purpose for release: ☐ continuity of medical care and confirming my diagnosis

☐ Other:_____

ITEMS REQUESTED:

Hospitals and SNF/ALF if Applicable:

☐ Complete Record of last **two** Hospital Admissions to include: Discharge Summary, History and Physical, Diagnostic Imaging Reports, Radiology, Pathology Reports, and Surgical Reports

☐ Labs ☐ Advance Directives ☐ DNR

☐ Other:_____

Physicians and Treatment Centers:

☐ Current History & Physical, and office visit notes, for **six months** prior to hospice admission

☐ Reports to confirm diagnosis

☐ Continuous office visit notes after hospice admission

This authorization is valid for 365 days, following the date of signature. This authorization may be revoked by written notice at any time, except to the extent that action has already been taken. Hospice of Marion County Inc. does not and has not conditioned treatment, payment, admission or eligibility of benefits upon signing this document.

I understand that the information disclosed to Hospice of Marion County will not be redisclosed to another agency except in the normal course of hospice care which includes the assurance of continuity of care, for reimbursement, for quality assurance and utilization review, and as required by law and regulatory agencies. I understand that health information disclosed pursuant hereto is subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act.

I authorize release of my Medical Records that will include sensitive information.
☐ Mental Health Care ☐ HIV Test Results or Infection Status
☐ Alcohol and/or Drug Abuse Diagnosis and Treatment Records.

_____ _____

Signature **Date**

I have read this Consent for Release of Information and I agree that a copy of this consent is as acceptable as the original.

_____ _____

Patient's Signature **Date**

Patient is unable to sign because:_____

_____ _____ _____

Patient Representative Signature Relationship Date

Form # H-00200	Date: 10/13

WHITE - Chart YELLOW - Patient