ACTIVE HOME HEALTH CARE

1495 Forest Hill Blvd, Suite A West Palm Beach, FL 33406

AUTHORIZATION FOR RELEASE OF PATIENT-IDENTIFIABLE HEALTH INFORMATION

Form may be sent directly to the company office by mail or faxed to (561) 300-2115.

Home health medical records may also be accessed online. Please call (561) 968-5553 for guidance.

Patient Name: (Last name, First name, Middle initial)				Phone Number:		
Date of Birth:				Medical Record Number:		
(MM/DD/YYYY)				(Agency use only)		
Disciplines:	RN	PT	ОТ	ST	MSW	ННА
The type of information to be used or disclosed is as follows (<i>check the appropriate boxes</i>):				The type of information to be disclosed for the following purpose (<i>check one box</i>):		
	Admission paperwork, All visit notes, including including consent(s) OASIS assessments			Legal		
OASIS assessme	OASIS assessments only Plan(s) of Care			Insurance		
Follow-Up visit no	Follow-Up visit notes only Discharge/Transfer Summary			Self		
Dates of Treatment:				Continuation of Care		
I authorize Active Home Health Care Services to release health information to: Name of person or facility to receive health information						
Specify name/title of person to receive health information, if known						
Street Address, City, State, Zip Code						
Phone # Fax #						
Copies of the record may be (<i>check one box</i>):						
Turnaround time is by the next home health visit or (4) business days, whichever is sooner, upon receipt of completed written request.						
Mailed F	Mailed Picked up by			Faxed (only to other healthcare providers in urgent situations)		
I hereby authorize release of information in my medical record which may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), record relating to behavioral or mental health services, and treatment for alcohol and/or drug abuse. Initials						
Copies of records that are released for any reason are provided to you free-of-charge . Per Medicare guidelines, patient health information can only be released to the patient, the patient's legal representative(s), or the patient's representative(s) determined during the start of home health services.						
Signature of Patient:					Date:	
Signature of Patient: Signature of Patient Representative:					Date:	
Relationship to Patient:					Date:	
Witness:	v agency on (i	mm/dd/vyyy)·			_ Date:	
Request received by agency on (mm/dd/yyyy): on Request approved by Administrator/Designee on						
			<u>(n</u>	ame)	(d:	ate)