IMPRINT

Admission Consent for Release of Information

Patient Name:_____

Address:_____City/State/Zip:_____

Date of Birth:_____Social Security Number:_____

to the individuals or representatives of the agencies listed below. I understand that the information given is intended to contribute to or be essential to my continuing medical care. This realize is in force as long as I am receiving treatment at Post Accute Medical. The names on this list can be deleted or added to only with my consent and additional signature and date.

Access May Be Granted to the Following Individuals: (Must list individual names)

_____ _____

_____ _____

_____ _____

_____ _____

Physician (S):

_____ _____

_____ _____

_____ _____

_____ _____

Other Oranization/Agency: (Home Health, Durable Medical Equipment, etc)

_____ _____

_____ _____

_____ _____

_____ _____

This consent may be revoked or amended at any time, but may not be applied retroactively once information has been released in good faith. Revocation must be in writing and provided to the Health Information Management department. Treatment and/or payment may not be conditioned on individuals consent. No information contained in the medical record will be given, sold, transferred, or in any way related to any other person or entity not specified in the consent or allowed through the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule. I further understand that information disclosed by this consent may be subject to re-disclosure by the recipient and no longer be protected by HIPAA. This facility, its employees, and officers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient/Legal Guardian/Authorized Representative Date

_____ _____

Authority to sign if not patient Date

_____ _____

Signature of Witness Date