Homer Senior Citizens, Inc.

3935 Svedlund Street
Homer, Alaska 99603
(907) 235-7655 Fax: (907) 235-3739

Consent for Release of Medical Records

Name: _____ SSN: _____

To: _____

Phone: _____ Fax: _____

I hereby request and authorize you to release all information you have pertaining to me as specified below:

INFORMATION:

☐ Hospital Records & Discharge Summary

☐ Psychological Evaluations

☐ Medical Records

☐ Psychiatric Evaluations

☐ Recent Treatment Plans or Assisted Living Plans (IHP.IPP.IEP. etc.)

☐ CHOICE Medicaid Records

Furthermore, I give my permission for RN, Office Manager, Administrative Assistant or Executive Director of Homer Senior Citizens, Inc. Assisted Living Facility or Adult Day Services to pass medical information about me to:

☐ Family Members: _____

☐ Medical staff in the community involved in my care: _____

☐ Home Health Nurses: _____

☐ Exclusions: _____

RESIDENT/PARTICIPANT/REPRESENTATIVE'S SIGNATURE DATE

This consent is subject to revocation in writing at any time. This consent is valid for one year from the date noted herein, unless revoked earlier.