



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.

This transmission is intended only for the use of the individual or entity to whom it is addressed and contains information that is protected. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, distribution or copying of this information is prohibited. If you have received this transmission in error, please notify us immediately by telephone (call collect at the number provided above) and return the original documents to us at the address given above via the US Postal Service. Thank you for your cooperation.