COMPLETE CARE
GROUP

PATIENT NAME: _____ MR#_____

Complete Care Group coordinates a broad array of onsite medical services and seasoned professionals with specialized skills to perform them. We're here to assist residents and identify health care needs in order to keep them as healthy as possible. This program is available to you at no charge and you are not obligated to use the services available.

□ **Yes, I authorize Complete Care Group to initiate and coordinate medical services on my behalf if necessary.**

□ **Yes, I authorize Complete Care Group to order and sign for Durable Medical Equipment ("DME") on my behalf.** I understand that Complete Care Group is not financially liable to the DME agency and I accept financial responsibility for any charges for Durable Medical Equipment I receive.

□ **No, I prefer to initiate and coordinate my own medical services.**

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

1. Authorization:

a.) I authorize Complete Care Group to use and disclose the protected health information described below to coordinate medical services.

b.) □ I expressly authorize the release of Protected Health Information (PHI) to staff members of buildings and/or communities wherein I reside. Such buildings and/or communities shall include independent living, assisted living, skilled nursing, transitional care, memory care, and advanced care.

2. Effective Period: This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____. **OR** b. □ all past, present, and future periods.

3. Extent of Authorization

a. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records □ Communicable diseases (including HIV and AIDS)

□ Alcohol/drug abuse treatment □ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative and his or her relationship to patient