Daughters of SARAH SENIOR COMMUNITY

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Resident Name: _____ Date of Birth: _____ Social Security Number: _____

Address: _____

I, or my authorized representative, hereby authorize **DAUGHTERS OF SARAH NURSING CENTER, INC.** ("DOS") to release, request, and/or receive, to or from any hospital, any other healthcare facility, and any health care provider or entity, and I hereby authorize any hospital, any other healthcare facility, and any health care provider or entity to release to **DAUGHTERS OF SARAH NURSING CENTER, INC.,** my entire file of all personal health information that any such provider or entity may have regarding me, as well as any information regarding any care and/or treatment any such provider or entity may have provided or is providing to me (including the release of **Alcohol, Drug Use, Mental Health Treatment and Confidential HIV Related Information**).

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act and New York State Law understand that:

1. I may inspect and/or receive a copy of the information described on this Authorization by completing this form and signing below.
2. Information disclosed under this authorization might be re-disclosed by the recipient (except as provided for in Item #4 below), and this re-disclosure may no longer be protected by federal or state law.
3. Treatment and payment will not be conditional on whether this authorization is signed or not. Signing is voluntary.
4. By my specifically authorizing the release of HIV/AIDS, related alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization, unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493. This agency is responsible for protecting my rights.
5. Alcohol/drug treatment-related information or confidential HIV/AIDS related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.
6. I may revoke this authorization at any time by providing written notice to DOS, except to the extent that action has already been taken based on this authorization.
7. I understand that this Authorization is made at my request and will expire on: _____ or upon (i) discharge from DOS or (ii) the termination of all post discharge services coordinated by DOS, whichever shall last occur.

Reason for Release: •Evaluation for admission to DOS • Continuation of care at DOS or for post discharge care

Signed: _____ Date: _____

If not resident, source of authority to sign on behalf of Resident: _____

Name of health provider or entity to release information: _____

Address: _____