ST. CAMILLUS/SAN CAMILLO
AUTHORIZATION TO RELEASE RESIDENT/CLIENT PERSONAL HEALTH INFORMATION

Resident/Client Name:_____ ID #_____

Regulations specify only a legally competent resident/client or designated healthcare power of attorney for a person deemed incompetent are to receive, verbally or in writing, any personal health information regarding the resident/client. Permission for others to receive personal health information can only be granted by the competent resident/client or the healthcare power of attorney. The purpose of this form is to designate other individual(s), if any, who may receive personal health information regarding the resident/client. Permissions may be withdrawn at any time.

Designated Healthcare Power of Attorney:

_____
_____
_____

Alternate Healthcare Power of Attorney:

_____
_____
_____

Activated: Yes / No

I, the resident/client or legal representative named above, authorize the following individual(s) to also receive personal health information regarding the above-named resident's/client's health condition. (The relationship noted below is the individual's relationship to the resident/client.) Additional contacts may be listed on the back of this form.

1. Name:_____ Relationship:_____

   Phone:_____ Address:_____

   City:_____ State:_____ Zip Code:_____

   Authorized to receive: ☐ Healthcare Information ☐ Financial Information ☐ Both

   Exceptions: _____

   Date Permission Withdrawn: _____/_____/_____ Documented by:_____

2. Name:_____ Relationship:_____

   Phone:_____ Address:_____

   City:_____ State:_____ Zip Code:_____

   Authorized to receive: ☐ Healthcare Information ☐ Financial Information ☐ Both

   Exceptions: _____

   Date Permission Withdrawn: _____/_____/_____ Documented by:_____

I understand that the resident/client named above will be included in facility listings unless I opt out. If I choose to opt out, I understand that no information relating to my stay or services with St. Camillus/San Camillo will be released, except to the above-designated contacts. By checking the following box, I request to opt out of facility listings: ☐

Signatures:

Resident/Client:_____ Date:_____/_____/_____

Legal Representative:_____ Date:_____/_____/_____

Additional Authorized contacts (continued from page 1) include:

3. Name:_____ Relationship:_____

   Phone:_____ Address:_____

   City:_____ State:_____ Zip Code:_____

   Authorized to receive: ☐ Healthcare Information ☐ Financial Information ☐ Both

   Exceptions: _____

   Date Permission Withdrawn: _____/_____/_____ Documented by:_____

4. Name:_____ Relationship:_____

   Phone:_____ Address:_____

   City:_____ State:_____ Zip Code:_____

   Authorized to receive: ☐ Healthcare Information ☐ Financial Information ☐ Both

   Exceptions: _____

   Date Permission Withdrawn: _____/_____/_____ Documented by:_____

5. Name:_____ Relationship:_____

   Phone:_____ Address:_____

   City:_____ State:_____ Zip Code:_____

   Authorized to receive: ☐ Healthcare Information ☐ Financial Information ☐ Both

   Exceptions: _____

   Date Permission Withdrawn: _____/_____/_____ Documented by:_____

6. Name:_____ Relationship:_____

   Phone:_____ Address:_____

   City:_____ State:_____ Zip Code:_____

   Authorized to receive: ☐ Healthcare Information ☐ Financial Information ☐ Both

   Exceptions: _____

   Date Permission Withdrawn: _____/_____/_____ Documented by:_____