Authorization for Release and Use of Information

Client Identification:
Printed Name:____**Date of Birth:**__________________________

Address:____

____**Email:**________________________________

Social Security #:____**Telephone:**____________________________

This information is to be released to arrangeCARE from:

____

____

____

arrangeCARE may release information to the following:

Name:____

Relationship to Client____

Address____

City, State, ZIP____

Purpose of the request:
_____Consultation
_____Supports and services assessment and care plan
_____Ongoing care management and service coordination
_____Discharge planning
_____Medication management
_____Other – specify:____

Type of information to be released:
Verbal and/or written communications, including but not limited to medical, psychiatric, social, legal and financial information.

Drug and/or Alcohol, and /or Psychiatric, and/or HIV/AIDS Records Release
I understand that the requested information may contain reference to or results of HIV/AIDS testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party.

Time Limit & Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to Leah Cohen at arrangeCARE, 8127 Mesa Drive #B206 PMB317, Austin, TX 78759. Unless revoked, this authorization will expire 365 days or ______________________________ from date of signature.

Re-disclosure:
I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996. arrangeCARE and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Reporting:
I understand that arrangeCARE is obligated by law to report any suspected abuse, neglect and/or exploitation of an older adult or person with disabilities.

Signature of Client or Personal Representative Who May Request Disclosure:
I understand I can view or receive a copy of the protected health information to be used or disclosed. I authorize arrangeCARE to use and disclose the protected health information specified above.

Signature:____Date:____________________________________

Name:____________________________________Date of Birth__________________Relationship to Client______________________

Authority to sign if not Client:_________________________________ ____Copy of verification of authority

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