ELMCROFT™
SENIOR LIVING

Elmcroft Of Timberlin Parc
7620 Timberlin Park
Jacksonville, FL 32256

(P) (904) 519-9300
(F) (904) 519-6570

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Except as otherwise permitted or required by law, we may not use or disclose your protected health information without a valid authorization from you. You are not obligated to provide an authorization to disclose your protected health information; it is voluntary. If you do provide an authorization to us, you are giving us permission to share your protected health information as specified in your authorization.

Subject to certain exceptions, you may revoke your authorization at any time. You must revoke your authorization in writing and must send it to our Local Privacy Officer. Please contact the Local Privacy Officer to complete the necessary form. A Revocation of Authorization form is HP Form 04. If we have already disclosed your protected health information in reliance on your authorization, your revocation will only prevent future disclosure.

We may not condition your treatment, payment, enrollment, or eligibility on the provision of an authorization, unless the authorization is necessary for your eligibility, enrollment, or risk determinations.

Patient's Name (print):_____

Patient's Date of Birth:_____

I authorize Facility to share the protected health information of the patient identified above ("Patient") in a manner consistent with this authorization with the following individual or entity ("Recipient"):

Recipient's Name (print):_____

Address:_____

Telephone Number:_____

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize the Facility to share the following protected health information about the Patient **(check all boxes that apply):**

☐ All protected health information

☐ Information regarding prescription drug coverage

☐ Protected health information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

☐ Protected health information regarding treatment for alcohol and/or substance abuse

☐ Protected health information regarding behavioral health services or psychiatric care

☐ Other:_____

_____

_____

_____

_____

The purpose of the requested use or disclosure is **(check all boxes that apply):**

☐ At the request of the Patient or the Patient's personal representative

☐ Other:_____

_____

_____

_____

_____

The Facility may share the Patient's protected health information in a manner consistent with this authorization until the earlier to occur of one year after the date on this authorization or until I revoke the authorization.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I understand the following:

- I may keep a copy of this authorization, and may contact the Facility's Local Privacy Officer to get a copy if I do not have one.

- Information disclosed by the Facility to the Recipient pursuant to this authorization may be subject to re-disclosure by the Recipient, and under most circumstances, is no longer protected by applicable privacy law. The Facility cannot control re-disclosure by the Recipient.

This form must be signed by either the Patient or by the Patient's personal representative.

If this form is signed by the Patient's personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative's authority to act on behalf of the Patient:_____

_____

_____

_____ Date:_____

Signature of Patient or Patient's Personal Representative

Current Contact Information for Patient or Personal Representative signing this form:

Name (print):_____

Address:_____

Telephone Number:_____

Email:_____

Submit this form to the Facility's Local Privacy Officer.