



**AUTHORIZATION FOR THE USE OF DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

(Patient Name)

(Date of Birth)

(Date of Admission)

I hereby freely and voluntarily authorize **Destination Life** to:

_____ Release/disclose records of my health information to:

_____ Obtain records of my health information from:

(Individual, Facility, Organization) (Telephone Number)

(Address) (Fax Number)

(City, State, Zip)

The purpose for this disclosure is:

- To assist in continuing care
- To assist in treatment planning
- To keep the above informed of patient's progress
- Other (specify) _____
- To assist in legal investigation
- To coordinate discharge planning/placement
- To assist in patient use

The information to be released/obtained included:

- Discharge Summary
- Lab, X-rays, EEG, EKG
- Psychological Testing
- Educational Assessments/Testing/Evaluations and Records
- Transition of Care Packet (Discharge Plan Part I, After Care/Discharge Plan Part II, Medication Reconciliation Document, Patient Safety Plan and Patient Advance Directives Acknowledgements)
- Other (specify) _____
- Treatment Plans
- History and Physical
- Immunization Record
- Psychiatric Evaluation
- Verbal exchange of information
- Substance Abuse Treatment

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to which disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not rediscover them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law. This consent expires on (date): _____

Patient Signature

Date

Parent/Guardian/If Authorized Representative (Describe: _____)

Date

Witness Signature

Date