Autumn View Hospice, LLC
"Caring Together"

Authorization of Release of Healthcare Information & Protected Health Information

Telephone Number: _____ Fax Number: _____

Patient's Name: _____ Date of Birth: _____
Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Autumn View Hospice, LLC
Address: 1350 Scenic Hwy Ste 266
City: Snellville State: GA Zip Code: 30078

I authorize you to release the following information to Hospice:

- Order for Hospice
- History & Physical (With in the last 12 months)
- Blood work
- Nurses Notes
- Physician Orders Medication Order and Prescriptions
- Other: _____

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.

_____ _____
Patient Representative Date

_____ _____
Hospice Representative Date

PLEASE FAX ALL RECORDS TO: 404-795-0744