Kalamazoo Functional Rehab Team

SIGNED CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth _____ Claim #_____

READ FIRST: Before you decide whether or not to let Kalamazoo Functional Rehab Team share some of your confidential information with another agency or person, an Advocate at Will can discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want Kalamazoo Functional Rehab Team to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that Kalamazoo Functional Rehab Team has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Kalamazoo Functional Rehab Team to release some of my personal information to certain individuals or agencies.

I, _____, understand that Kalamazoo Functional Rehab Team and its employees/contractors will need to share information with the care team directly involved in my care including referring/treating physicians, case manager, insurance, and all members of the rehabilitation team.
In addition, I authorize Kalamazoo Functional Rehabilitation* to share information related to my care with:

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

_____ **(initials).** ***I understand and accept the risk that electronic mail (e-mail) has a risk of being intercepted and read by other people, and KFR Team may need to email my information to members of my team.***

- Information shared will be related to medical treatment and rehabilitation as well as social information needed for the coordination of a safe living situation.
- This consent includes **medical imaging (photo, video, and/or audio)** of me or my home environment. I understand that the imaging may be used in my medical record, for purposes of education for me or my family/caregivers, for staff/clinical education, or for communication of information to members of my care team. I understand I will not receive any payment for this imaging. Photos/recordings will be used for documentation of events or to further my care and not for advertisement/marketing without additional consent.
- I understand that I do not have to sign a release form. I do not have to allow Kalamazoo functional Rehab Team to share my information. Signing a release form is completely voluntary. This release is limited to the information noted above. If I would like Kalamazoo Functional Rehab Team to release information about me in the future, I will need to sign another written, time-limited release.
- I understand that releasing information about me would give another agency or person information about me and would confirm that I have been receiving services from Kalamazoo Functional Rehab Team.
- I understand that Kalamazoo Functional Rehab Team and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.
- I understand that this release is valid when signed, and I may withdraw this consent at any time via written notification and indicating effective date of revocation.
- Kalamazoo Functional Rehab Team **SAFETY GUIDELINES for weapons, animals and social medi**a has been reviewed with me and I agree to comply.

Signature (patient or representative): _____ **Date:** _____

Printed Name/Relationship of representative: _____

Witness: _____

Release is valid for 1 year from date signed above.