GRACE LIFE CARE
AGING LIFE CARE™ CONSULTANTS

RELEASE OF PROTECTED HEALTH INFORMATION

Name of client: _____ Date of birth: _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to any representative of GRACE LIFE CARE, INC., pursuant to 45 C.F.R. Section 164.501 (Protected Health Information) described herein.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that representatives of GRACE LIFE CARE, INC. may obtain the necessary information (written and verbal) to manage my medical care and assist in my future treatment and living arrangements.

This authorization shall expire in 10 years following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to GRACE LIFE CARE, INC.

I understand that any information that is disclosed to GRACE LIFE CARE, INC. pursuant to this authorization will not be disclosed by any representative of GRACE LIFE CARE, INC. except as authorized by me or my attorney in fact.

I understand that if I refuse to sign this authorization to release my complete medical record, GRACE LIFE CARE, INC. may not be able to manage my care. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____

Client or Authorized Representative

_____

Printed name of Client or Authorized Representative

_____

Authorized Representative's relationship to client

_____

Effective Date