THE COMMUNITY HOSPICE

Authorization to Release/Disclose Health Information

I hereby authorize The Community Hospice to release information from the medical record of:

Child's Full Name: _____ Date of Birth: _____

Guardian's Name: _____ Date of Birth: _____

Mailing Address: _____ State and Zip: _____

Covering the period of health care from: _____ to: _____
Today's Date One year later

Type of visits: Bereavement Services / Grief Support
Information to be disclosed: Plan of care, appointment information, session notes, assessments, concerns

1. This information is to be disclosed to:
Name of School or Organization:_____

Address: _____
For the Purpose of: scheduling appointments, treatment plan, concerns
Preferred Format of release: verbal, paper, electronic, email
The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected. I understand that The Community Hospice is not responsible for the re-disclosure of protected health information that I have authorized to be disclosed in an email format to an internet address.

2. I understand The Community Hospice will not condition treatment on the execution of this authorization. I understand the organization must provide me a copy of this authorization upon request, signed or unsigned. I understand this authorization may be revoked in writing at any time except to the extent that action has already been taken based on this authorization. Unless revoked, this authorization will expire six months from the date of signature, or on the following date, event or condition:

3. I understand that information released pursuant to this authorization is governed by State and Federal confidentiality laws; however some re-disclosures are not protected under Federal law.

4. I understand that re-disclosure of any drug and alcohol related information is bound by Federal Law 42 Part 2 CRF governing confidentiality of alcohol and drug abuse patient records and that re-disclosure of this information to a party other than the one designated above is forbidden without my additional written authorization.

5. Under State law anyone who illegally discloses HIV related information may be punished by a fine of up to $5,000 and a jail term of up to one year. The facility, its employees, officers and physicians are here by released from any legal responsibility or liability for disclosures of the above information as described above.

Signature of Parent/Legal Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____