AUTHORIZATION TO RELEASE
MY PERSONAL HEALTH INFORMATION

BAYADA®
Home Health Care

Dear BAYADA Home Health Care:

Re: Client Name: _____ Client #: _____

Please release the following information (describe type of information and dates of services, if applicable):

_____

_____

To:

Name: _____

Address:_____

City: _____State: _____ Zip Code: _____

Telephone: _____

For the following reason/purpose:

_____

I understand that:

1. This authorization is voluntary and is not required for me to continue receiving treatment from BAYADA.

2. This release specifically covers any confidential information pertaining to HIV status, mental health treatment and substance abuse records. I am aware that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this information cannot be released without my consent and I have the right to inspect the information that is released.

3. I have the right to inspect the information to be released and to refuse to authorize the release following my inspection.

4. I may revoke this authorization in writing at any time by notifying BAYADA; but until BAYADA receives my written revocation, they may continue to release information about me to the person or organization listed above.

5. This authorization will expire on _____ or one year after the date of my signature, whichever is shorter.

6. There is a possibility that the information being disclosed as part of this authorization could be subjected to re-disclosure by the person receiving the information and no longer protected under HIPAA.

_____   _____
Signature of Client or Client's Representative   Date

If client is unable to sign this form, please complete the following:

Printed Name of Client's Representative: _____

Relationship to Client: _____