Authorization to Release Confidential Medical and Mental Health and Drug or Alcohol Abuse Treatment Information

__________________________, a resident of Copps Residential Care Facility hereby authorize the Copps residential care facility administrator or administrator designee to *release confidential information* from my records to the following AND *receive confidential information* from my records of the following:

Name __________________________________ Title ___________________

Agency/Organization ____

Address ____

City __________________________________ State _____________ Zip ______________________

The information listed below shall be released:
[] Physician Orders
[] History and Physical
[] Labs
[] Medication records
[] Diagnosis
[] Procedure and Results

It is my understanding that the information released shall be used solely for the following purposes:

Admission criteria / Continuum of care

Exchange of Medical information to facilitate ongoing treatment

As a resident or legally authorized representative of the resident I/we have the right to revoke this release of confidential information at any time by notification of the facility administrator and by signing the revoke for release of confidential information form that is available from the facility administrator office.

I understand that this authorization shall in no way affect my care services at Copp's Residential Care Facility. I understand services are not contingent upon the signing of this release. I have signed this authorization form freely and voluntarily.

This consent for release shall expire within 12months _______________ (write in expiration date) from the date of signing or at the time the residents terminates residency at the facility or at the time of the resident's death.

This information has been disclosed to you from records whose confidentiality is protected by State and Federal Law. Federal regulations prohibit you from making any further disclosure of the records without the specific written consent of the person to who it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient. **The information authorized for release may include records which may indicate the presence of a communicable or venereal diseases which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

_______________________________________ ________________________
Signature of Resident Date

_______________________________________ ________________________
Signature of Legally Authorized Representative of Resident Date

_______________________________________ ________________________
Signature of Person Approved To Release Information Date