Name: _____

ALL GENERATIONS
ADULT DAY CENTER

DOB: _____

AUTHORIZATION TO RELEASE / RECEIVE INFORMATION (circle "release" and/or "receive")

I authorize: _____ **All Generations Adult Day Center**
(include _____ AND 2061Exchange Drive
address, _____ St. Charles, Mo 63301
phone,& _____ Phone**: 636-410-8303**
fax) _____ Fax no: **636-410-7707**
Relationship to client: **PHYSICIAN**

to exchange the following information:
☐ Verbal only ☐ Written only ☐ Verbal and Written

Description of information to be released: _____

_____ Participant's initials (indicates agreement with information to be released and Mental Health information may be exchanged)

I understand that this will include information relating to (client initial, if applicable):
_____AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
_____Treatment for alcohol and/or drug abuse
_____Treatment for Psychiatric Issues

regarding_____

(print participant's first, middle and last name)

for the purpose of : _____

(for example: continued services, evaluation…)

Prohibition of Redisclosure: This information has been disclosed from records protected by Federal confidentiality rules (42 CFR Part 2) and HIPAA privacy rules. The Federal rules prohibit making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand that my refusal to consent to the release of the above information will prevent the disclosure of the information. I understand that I have the right to revoke this authorization at any time by providing written notification. I understand that revocation does not include information released prior to my revoking this authorization. I understand that I have the right to inspect, and/or copy the information to be released by this authorization and that I will receive a copy of this authorization.
This authorization will expire 1 year from date signed unless otherwise noted here: _____

_____ _____ _____
Signature of Participant / Caregiver/ Legal Guardian **Initials** **Date**

_____
If not signed by client, specify relationship

_____ _____
Witness **Date**

A PHOTCOPY OR FACSIMILE OF THIS AUTHORIZATION SHALL HAVE THE SAME FORCE AND EFFECT AS AN ORIGINAL

Date Sent/Faxed:_____

Release of Information Info Request Guide

Source:	**List these items:**
Alcohol/Drug Agency	Evaluations, treatment plans, notes, labs, discharge summary
Div of Aging	Evaluations, grievances
Emergency Contacts	Exchange of info regarding safety planning, appt. information
Family Support Div.	Food stamps, spenddown, income information, info necessary to apply/maintain benefits
Guardian	Current treatment concerns (while awaiting guardianship papers)
Hospitalization	Chart summary, admission summary, labs, physical, evaluation, notes, discharge summary, diagnosis, consultations
HUD or NECAC	Housing information
MRDD/Regional	Evaluations, record of services, diagnosis
Physicians	Physicals, labs, medications
Primary Care	mental health records, dental records, history and physical, EKG, ultrasound reports, consultation report(s), immunization report(s), hepatitis information, medication records, discharge summary, Echo stress test Holters, laboratory, other health providers.
Psychiatrists	Evaluations, medications, notes, diagnosis
Schools	IEP, evaluations, diagnoses, attendance, disciplinary reports, grades
Social Security	Income info, info necessary to apply/maintain benefits
Spouse/Signif. Other	Appointment info, exchange of medication info, safety planning
Therapists	Evaluations, notes
Voc Rehab	Work history record, assessments