AUTHORIZATION TO **OBTAIN** and **RELEASE** HEALTH CARE INFORMATION

| **Client Name:** | **Date of Birth:** |
|---|---|

**I, or my authorized representative, authorize the following individual or agency to obtain and release written and oral health care information about my needs and required services with care and supported housing providers with the intention of assisting me in locating appropriate housing or care services.**

| Name or agency to receive and release information: **Options For Seniors LLC** | |
|---|---|
| Address: **9805 NE 116th Street #7492** | |
| City/State/Zip: **Kirkland, WA 98034** | |
| Phone: **425-827-0894** | Fax: **425-893-8278** |

**Type of Housing Providers to receive information:** ☐Retirement and Assisted Living Communities ☐Adult Family Homes ☐Alzheimer's and Dementia Care ☐Skilled Nursing Facilities ☐In-home Care ☐Companion Services

**The information released or shared may include:** ☐Face sheet ☐Care plan ☐History & physical ☐Medication current and history ☐Psychological reports ☐Discharge plan ☐Social history ☐Lab results ☐ Treatment and aftercare plans ☐X-ray/imaging reports ☐Team notes ☐Initial assessment ☐Immunization record ☐Court documents ☐Evaluation & recommendation ☐Consultation reports(Dr./specialty & name):_____ ☐Other (please specify):_____

***This information is being used ONLY for the purpose of providing the client with housing and care options.***

| **Specific Authorization for Release** | **Type of Information** | **Authorizing Initials** |
|---|---|---|
| Authorization may include the release of the information listed at the right, only if I have placed my initials on the appropriate line: | Mental health evaluation/treatment*<br>AIDS/HIV-related*<br>Sexually Transmitted Diseases<br>Substance abuse | _____<br>_____<br>_____ |

*If I am authorizing the release of HIV-related, substance abuse treatment, or mental health treatment information the recipient is prohibited from re-disclosing without my permission.

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I may request to see this information during normal business hours. I understand that I can revoke my authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire _____(date or event). Authorization will expire one hundred and eighty days after this document is signed unless otherwise specified. I understand that I must revoke this authorization in writing. If I revoke my authorization it will not affect any action already taken by Options For Seniors LLC. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need to sign this form in order to assure appropriate referrals. I understand that once Options For Seniors LLC has disclosed healthcare information, the recipient may re-disclose it in some circumstances. I have read this form, or it has been read and explained to me, and I understand its content.

| **Authorizing signature:**_____ **Date:**_____ |
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| Relationship to client: ☐Self ☐Legal representative ☐Nearest living relative ☐Other (specify below) |
| |

A photocopy of this signed authorization shall have the same force and effect as this original.