ROYAL PALM ADULT DAY CARE CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION (HIPAA)

Participant Information

Participant Full Name: _____

Date of Birth: _____

Authorization to Release Information

I hereby authorize Royal Palm Adult Day Care Center, Inc. to disclose and/or obtain my protected health information (PHI), including medical, social, and billing information, as necessary for coordination of care, services, and program participation.

This authorization permits the exchange of information with the following individuals and/or entities (check all that apply):

☐ Primary Care Physician
☐ Specialists / Medical Providers
☐ Case Manager / Care Coordinator
☐ Health Plans / Insurance Providers
☐ Family Member(s) / Caregiver(s) listed below
☐ Other (specify): _____

Authorized Recipient(s)

Name: _____

Relationship: _____

Phone Number: _____

Purpose of Disclosure

The purpose of this disclosure is to coordinate care, facilitate services, ensure participant safety, and comply with applicable regulatory and administrative requirements.

Duration of Authorization

This authorization shall remain in effect from the date of signature and shall expire upon the participant's discharge from Royal Palm Adult Day Care Center, Inc., unless revoked earlier in writing.

Right to Revoke

I understand that I may revoke this authorization at any time by submitting a written request to Royal Palm Adult Day Care Center, Inc. I understand that revocation will not apply to information already released prior to receipt of the written revocation.

Acknowledgment & Signature

I understand the contents of this authorization and voluntarily agree to the release of information as described above.

Participant / Legal Representative Signature: _____
Printed Name: _____
Date: _____

Relationship to Participant (if applicable): _____