MEADOWLARK HOSPICE
709 Liberty, Clay Center KS 67432
Phone: (785) 632-2225 Fax: (785) 632-3557

Release of Information
( )

Patient	Patient No:

RELEASE OF INFORMATION: I authorize Meadowlark Hospice to obtain copies of medical and billing records and to keep records which include necessary personal information about my medical condition, family and finances during the time I am under care.

Consent to Disclose General Information (HIPAA Directory)

I understand that my name, address, and general condition may be given to members of the clergy, my family, individuals involved in my health care, as well as those listed under *Significant Others* on the *Psychosocial Assessment.*

I do _____ I do not _____ give consent for this information to be disclosed. (Initial option)

Exceptions noted on *Psychosocial Assessment* form: _____

_____

HIPPA Authorization

I authorize Meadowlark Hospice to disclose the confidential health information on the above-named patient to those organizations listed below or in the manner listed below for the purpose of enhancing the quality of the patient's life and for the purpose of encouraging community involvement with the Meadowlark Hospice program.

Identified persons on the *Psychosocial Assessment*
Physician and/or Physician's office
Pharmacy
Skilled nursing facility
Home health agency
Hospital
Health organization
Community meal services
Utility companies and community emergency preparedness
Durable medical equipment company
Clergy
Area Agency on Aging
Meadowlark Hospice Publication (acknowledgments and/or gifts related to this patient)
Third party reimbursement (Insurance/Medicare/Medicaid)
CAHPS survey per medicare regulations
Meadowlark Hospice Memorial Service

I give consent and approval for notations to be made on Meadowlark Hospice records concerning the medical, nursing, psychosocial, spiritual and personal information necessary for Hospice to fulfill its functions.

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Release of Information
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Patient	Patient No:

I understand that my health information may contain information relating to: HIV, contagious diseases, psychiatric treatment, mental health treatment, substance abuse treatment, or other conditions which may be specifically protected by law and I authorize disclosure of that information. I understand that once my health information has been disclosed, it will no longer be subject to federal privacy regulations and may be re-disclosed by the person receiving it.

I understand that I may refuse to sign this Authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research, or the reason for my treatment is to disclose information to another person.

I understand that I may see and copy the information described on this form as provided by federal regulation, and that I will get a copy of this form after I sign it.

This authorization will expire when the patient has been discharged from hospice, expires, or no more than one year from date of signature, whichever occurs first.

I understand that I can revoke this authorization in writing or orally but that any revocation is not effective for disclosures that have already been made. To revoke this authorization, contact:

Compliance Coordinator
Meadowlark Hospice
1-785-632-2225

I understand that all information is treated in a confidential manner.

I have been able to discuss the above conditions with a member of the Meadowlark Hospice staff and have had my questions answered to my satisfaction.

Signature of Patient or Patient's Personal Representative _____ Date _____

If Personal Representative, Relationship to Patient
(Person identified by patient as being family/significant other or legally responsible person for this patient)

Witness _____ Date _____

 Revised: 05/10/07csc 5/2015 ab 11/2016 AB 04/04/17