ClearView Communities
611 West Patrick Street
Frederick, MD 21701
240-439-4900
Fax 301-378-0113

ClearView
COMMUNITIES

AUTHORIZATION TO RELEASE AND OBTAIN HEALTHCARE INFORMATION

_____ _____

Resident Name **Date of Birth**

I request and authorize *ClearView Communities* to release and obtain healthcare information for the above named resident to/from:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

Circle one: Family Member Primary Care Physician Psychiatrist Therapist Employer

Other: _____

This authorization applies to all medical records, mental health records, chemical dependency/substance abuse records, HIV and STD records, unless otherwise specified. I understand that I may inspect the information to be used or disclosed, as provided in 45 CFR 164.524.

Exclusions: _____

Authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. This authorization will expire one year from the date signed. Authorization will expire thirty days after discharge from ClearView Communities. Any future Authorization will supersede this authorization.

_____ _____

Witness Signature Resident Signature

_____ _____

Date Healthcare Power of Attorney, if applicable

Notice to Recipients of Information: The information disclosed to you was taken from records of which the confidentiality is protected by State and Federal Laws. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Revised 5/2016