Avalon Health Care Management

Connected Care Center
Powered by PointClickCare

REQUEST AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize ____________________________________(the facility) to grant access for the below named party (Requestor) to my medical records through the Connected Care Center portal. A separate form must be used for each person requesting access. Residents requesting access to their own records should use the "Connected Care Center Resident Enrollment Form."

____

Resident Name Date of Birth

____

Requester's Full Name Email Address Cell Phone (must be able to receive text)

Understandings & Agreements of <u>Requestor</u>

1. This authorization is voluntary, and the facility cannot condition treatment based on the signing of this authorization.
2. The resident may revoke this authorization at any time by notifying the facility in writing. It will not have any effect on any actions taken prior to receiving the revocation.
3. All claims against the facility for the release of the requested information are waived.
4. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility.
5. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

____

Signature of Requestor

____

Date

____

Print Name

____

Relationship to Resident

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Understandings & Agreements of Resident (or Legal Representative)

1. This authorization is voluntary, and the facility cannot condition treatment based on the signing of this authorization.
2. The resident may revoke this authorization at any time by notifying the facility in writing. It will not have any effect on any actions taken prior to receiving the revocation.
3. All claims against the facility for the release of the requested information are waived.
4. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility.
5. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

The access granted to the above Requester can be customized for each account. Select the items you want to limit/restriction for the above requester. (Remember, the selected items will NOT be accessible for the account being created for this Requester; if nothing is selected full access will be granted.)

____ Allergies	____ Immunizations
____ Care Plan	____ Medications
____ Diagnoses (all)	____ Practitioners
____ Diagnoses (confidential)	____ Progress Notes
____ Lab and Radiology	____ Vital Signs

If the below signature is not the signature of the resident receiving care, please indicate the legal authority to sign on the Resident's behalf:

__ I am the resident's attorney-in-fact, and I have attached to this authorization a valid power of attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the resident's medical records. I understand that the resident's DPAHC is effective only when the resident's physician has determined that the resident has lost the capacity to make informed health care decisions.

__ I am the resident's legal guardian, and I have attached to this authorization a valid appointment of guardianship from a probate court.

__ If the resident is deceased: I am the executor / administrator of the resident's estate, and I have attached to this authorization a valid appointment as such from a probate court.

__ The resident has executed a legally binding instrument granting me the authority to obtain his / her medical records, and I have attached a copy of that instrument to this authorization.

__ The resident's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the resident's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, i.e., a power of attorney or probate court order.

______________________________ ______________________________

Signature of Resident or Resident's Legally Authorized Representative

Date