GenevaWoods
HEALTH SUPPLIES

RELEASE OF INFORMATION FORM

GENEVA WOODS **RECEIVING** CLIENT RECORDS

GENEVA WOODS **RELEASING** CLIENT RECORDS

Authorization For Access, Use, And/Or Disclosure Of Information

☐ By signing below, I authorize my health care provider(s) and/or entities with information regarding my medical history and treatment to release it to Geneva Woods Health Supplies, LLC and/or its subsidiaries.

OR

☐ By signing below, I authorize Geneva Woods Health Supplies, LLC and/or its subsidiaries to release and/or discuss my Geneva Woods Health Supplies, LLC and/or its subsidiaries client records to:

Name: _____ Phone: _____

Name: _____ Phone: _____

☐ All Dates of Service

OR

☐ Date Range: _____ to _____

☐ Entire Chart

OR

☐ Specific Information

Other: _____

The following items must be initialed ONLY if they are to be included in the use or disclosure of the above records:

_____ MENTAL HEALTH information and/or records

_____ DRUG/ALCOHOL DIAGNOSIS treatment, and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed

_____ HIV/AIDS related health information and/or records

_____ GENETIC TESTING information and/or records

I understand that I have the right to refuse to release my medical records and that by signing this agreement I waive this right. I also understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA privacy rule. However, the recipient may be prohibited from disclosing my health information under another applicable state or federal laws and/or regulations. This consent is valid for whatever time period is reasonably necessary for the purposes of Geneva Woods Health Supplies, LLC and/or its subsidiaries to carry out my treatment, payment, and/or their healthcare operations and shall remain in effect until such time as I revoke it in writing. Except to the extent that action has already been taken in reliance upon this authorization, I understand that I have the right to revoke this authorization at any time by giving written notice to Geneva Woods Health Supplies, LLC and/or its subsidiaries.

SELECT ADDITIONAL PURPOSE/S OF DISCLOSURE (IF APPLICABLE):

☐ At the request of the individual ☐ Legal ☐ Referral ☐ Insurance Coverage ☐ Other: _____

SIGN HERE

I understand that Geneva Woods Health Supplies, LLC and/or its subsidiaries does not condition treatment or payment if I refuse to sign this authorization.

Client Name _____ Date of Birth _____

Signature of client or client's legal representative _____ Date _____

Printed Name of Client's Legal Representative _____ Relationship to Client _____