Senior Care Partners P.A.C.E.

Participant Name:
Date of Birth:
CSC:

Authorization to Disclose Protected Health Information

Participant Name:_____Birth Date: _____

Address:_____City/State/Zip:_____

Purpose of Release:	
☐ Treatment/Coordination of Care	☐ Insurance/Billing
☐ Personal	☐ Legal
☐ Guardianship	☐ Disenrollment
☐ Other (Please specify):_____	

Select the Senior Care Partners P.A.C.E. facility(ies) you are requesting records from:

- ☐ **Albion:** 290 B Drive N, Albion MI, 49224
- ☐ **Battle Creek:** 200 W. Michigan Ave, Battle Creek, MI 49017
- ☐ **Kalamazoo:** 445 W. Michigan Ave, Kalamazoo, MI 49007
- ☐ **Portage:** 800 E. Milham Ave, Portage, MI 49002
- ☐ **Other: (Facility Name/ Address)** _____

_____

I authorize release TO:

Name/Facility:: _____Phone/Fax#:_____

Address:_____City/State:_____Zip: _____

Date of Service Range (month/year): From: _____ To: _____

Information to be Released (select all that apply):	
☐ Clinic Notes ☐ LifePlan ☐ All Discipline (IDT) Progress Notes ☐ Immunization Records ☐ Laboratory Results ☐ Disenrollment Packet ☐ Complete Record: All notes, medications, orders, etc. ☐ *Other (must specify):* _____	☐ ***Drug/Alcohol Treatment***** ☐ ***HIV/AIDS Information***** ☐ ***Mental Health Treatment***** ☐ ***Sickle Cell***** ☐ ***STD/Communicable Diseases*****

Senior Care Partners P.A.C.E.

Participant Name:
Date of Birth:
CSC:

Authorization to Disclose Protected Health Information

****I hereby consent to disclose the above bold/sensitive information. Participant signature only required if sensitive information is being requested for release.**

Participant's Signature: _____Date: _____

****

I understand that:

- Requests for documentation releases will be processed within 30 calendar days.
- By signing this Release of Verbal Information Authorization, Senior Care Partners P.A.C.E. will be permitted to discuss my protected health information identified above with the individuals designated by me above.
- Multiple requests are authorized if the purpose of the request remains the same.
- I may **revoke** this Authorization in writing at any time, except to the extent that this action has already been taken in response to this Authorization. If I chose to revoke this authorization, I must send a written request to: Senior Care Partners PACE, Attn: Health Information Management, 200 W. Michigan Ave., Battle Creek, MI 49017.
- Information disclosed pursuant to this Authorization may be subject to re-disclosure by the individuals designated by me above and may no longer be protected by the HIPAA Privacy Rule.
- This authorization is voluntary, and the disclosure is made at my request.
- Treatment, payment, enrollment, or eligibility may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule.
- This authorization will automatically expire one year from the date signed below, unless revoked in writing, or participant is dis-enrolled from the PACE program.

_____ _____

Participant/Legal Representative Signature **Date**

_____

If signed by Legal Representative, Indicate Legal Representative Type Above

For HIM Office Use Only

ID: ☐ Driver's License_____ ☐ State ID _____ ☐ Military ID _____

If signed by legal representative, indicate documentation: ☐ Death Certificate ☐ Power of Attorney ☐ Living Will

Processed by:_____Date:_____Mailed/Faxed /Given by: _____