

ASSISTED INDEPENDENCE, LLC.

www.assistedindependence.care

P.O. Box 1683, Columbus, IN 47202

812-374-9450



AUTHORIZATION FOR RELEASE OF HEALTH RECORDS PURSUANT TO 45 CFR 164.508 **HIPAA**

To: ASSISTED INDEPENDENCE, LLC., (the "Covered Entity") You are hereby authorized to release the following information and records in your possession concerning **[individual]** _____ to Assisted Independence, LLC., who is also authorized to release the following information and records in possession to healthcare professionals concerning the care of the individual.

	Copies of all charts, records, correspondence, physicians' orders, progress notes, nurses' notes, medication records, therapy notes, laboratory reports, x-ray reports, consents, operative notes, pathology reports, anesthesia reports, admission and discharge summaries and any other medical information.
	Other: _____

Individual Information:

Name: _____ D.O.B: _____

This authorization is given in compliance with 42 CFR § 164.508. This information is requested for the purpose of facilitating Day Habilitation, Participant Assistance and Care, Respite, Recreational Therapy, and/or Residential Habilitation Services to be provided to the individual by Assisted Independence, LLC. You are authorized to discuss with Assisted Independence, LLC all matters concerning the medical treatment, condition, prognosis, and the records that are being requested. Please do not discuss or disclose such information to any person(s) without written authorization from me. This Authorization shall remain valid until revoked by me in writing and revokes all prior authorizations for release of information. A photocopy of this Authorization shall be deemed the same as one bearing my original signature. I understand that I may revoke this authorization at any time by providing written notice to the Covered Entity, except to the extent the Covered Entity has taken action in reliance on this Authorization or if this Authorization was obtained as a condition of obtaining insurance coverage other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Individual or Individual's Representative Signature: _____

Printed: _____

Relationship [guardian]: _____

Date: _____

All portions of this form must be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will not be considered.