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**Authorization to Release Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient’s name) give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (employee/3rd party) to share and receive information related to my health, with my team of practitioners through At Your Door: Visiting Healthcare Services.

Personal health information is protected by the Health Insurance Portability and Accountability Act (HIPAA). When you sign this form, you agree to the following: At Your Door: Visiting Healthcare Services has permission to give my personal health information to the person or organization listed in the section above. Records may contain information on specific medical care or services I received. They may also contain information created by others. The information may include medical, claim, or benefit records.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*This form is typically used for independent living or home patients when the practitioner wants to communicate with a service coordinator.*