La Casa Adult Day Health Center, Inc.
909 Blanco Circle, Suite B
Salinas, CA 93901
Tel: 831-998-8130 | Fax: 831-676-0189

RELEASE OF INFORMATION

I _____ understand that La Casa ADHC Center may need to obtain the below checked records and related information from physicians and other health care professionals in order to ensure continuity of care and proper reimbursement. I also authorize the Center to release medical records and related information to others for purposes of my health care including the administration and management of my health care and utilization review. I understand and agree that this authorization specifically includes my permission and consent to release any information regarding a diagnosis of AIDS or results of Human Immundeficiency Virus (HIV) tests. A photocopy of this authorization shall be as valid as the original.

(Participant or participant representative to initial each or mark "X" if unable)

___ Medical __ Psychological/Psychiatric __ Neurological ___ Consultations

___ Psycho-social History ___ Lab Reports ___ History and Physical ___ Radiology

__ Other _____

I understand that _____ ADHC will utilize this information with the utmost confidentiality.

_____ _____
Participant (Print Name) Participant (Signature)

_____ _____
Legal Representative (Print Name) Legal Representative (Signature)
Only if participant is unable to sign *Only if participant is unable to sign*

_____ _____
DATE (Valid for 1 year) Center Representative

*If participant is unable to sign or able to mark "X" only, please state reason:

_____

Participant Name _____ DOB _____