Request for and Authorization to Release
Medical Records or Health Information

I hereby request and authorize Senior Housing Specialist and its affiliates to receive copies of my Medical Records and or Health Information including medical history, diagnoses, medication lists and chart notes. I give permission for them to speak to my health care representatives on my behalf to gather information that relates and pertains to my long term care. I also ask that my Advisor be included in care conferences and discharge planning.

Name of Patient: ____

____
Signature of Patient or Person Authorized to sign for Patient

____
Date | Date of Birth

____
Address | City, State, Zip

____
Cell Phone | Home Phone

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Disclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure

Please send to:

Senior Housing Specialist
Email: tami@seniorhousingspecialists.com
Fax: 866-611-1634 / Direct Line: 866-611-1634