AUTHORIZATION TO RELEASE RECORDS / INFORMATION
FOR USES AND DISCLOSURES WHERE AUTHORIZATION IS REQUIRED

I hereby authorize the use or disclosure of Protected Health Information about me as described below.

(1) The name or other specific identification of the person(s) authorized to make the use or disclosure: _____

(2) The name or other specific identification of the person(s) authorized to receive the information:
Care To Stay Home
(Parker Wells, Kraig Nakano, Manuel Aranda or Other Company Representatives)

(3) Specific description of the information to be used or disclosed:
Long Term Care Insurance Policy Information, Home Care Benefits Information, and/or General Health Condition of Client, Medical conditions and Medical History

(4) The information may be used or disclosed for each of the following purposes:
Verification of Benefits and general policy/benefits provisions or requirements.
Care Coordination for client.

(5) I UNDERSTAND THAT BY SIGNING THIS AUTHORIZATION:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. (PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES)
- I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

- I understand this authorization will expire on (check and complete one):

☐ _____, 20_____, **or**

☒ On the happening of the following event: _____

_____

Care To Stay Home Services End or upon written notice from client

This form must be fully completed before signing.

_____ _____

Signature of Client or Representative Date of Client's or Representative's Signature

_____ _____

Client's Printed Name Witness

_____

_____

Client's Address

_____

Name of Personal Representative
(if applicable)

_____

_____

Description of Representative's Authority to Act for Client *(if applicable):*

NOTE: ATTACHING LEGAL DOCUMENTATION IS REQUIRED TO VERIFY THAT YOU ARE THE LEGAL REPRESENTATIVE (Guardian, executor, conservator, etc.) OR THAT YOU HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL.

A Copy of this form has been provided to the Client and/or their Representative.