

FORECASTLE HOME AND HEALTHCARE SERVICES. LLC HIPAA PRIVACY AUTHORIZATION FORM

HIPAA: We honor all rights of patient privacy and HIPAA Guidelines. I hereby restrict Forecastle Home and Health care Services. LLC to provide my health care information to the following person(s):

Name: ______ Phone: ______

Name:	Phone:		_
ame: Phone:			_
or receive from hospitals, phy	eby authorize Forecastle Home and lysicians or other agencies involved in are. I hereby give permission for the ther regulatory bodies.	n my care all medic	al records and
XVIII of the Social Security request. I request that payment Insurance. I understand that I	Act is correct. I authorize release of ant of authorized benefits from Medicam responsible for all amounts not all services rendered by Forecastle	all records required are, Medicaid, Priv paid by my insuran	to act on this vate Pay, and ce. If I am a private
of my right to make healthcar	rstand that the Advance Directive Acre decisions for myself. I understand d Directive so that my wishes may b	that I may express	wishes in a
I have made a Directive to Physician (Living Will):		Yes	No
I have made a Medical Power of Attorney:		Yes	No
To:	Phone: _		
I have made an Out of Hospital DNR:		Yes	No
I have made a Declaration of Mental Health:		Yes	No
Location of the above COPIE	ES if Yes		
Patient Signature: Name Printed		Date	
Legal Guardian: Name Printed		Date	
Relationship of Patient:			
Agency Staff:	Name Printed	Da	ate