ATTACHMENT E

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I, _____, hereby
(Resident's Name)
authorize the Facility, _____,
(Name of Facility)
to provide information regarding my medical history, mental or physical condition, care, or treatment as specified below:

This authorization is limited to disclosure to the following persons:

_____
_____
_____
_____
_____

This authorization is limited to the following types of medical information:

_____
_____
_____
_____
_____

The persons to whom records and information are disclosed pursuant to this authorization may use those records and information only for the following purposes:

_____
_____
_____
_____
_____

This authorization shall become effective immediately and shall remain in effect until _____.
(Date)

I 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. However, if I authorize the disclosure of my medical information to person(s) and/or organization(s) who are not health care providers or other people who not are subject to laws governing the disclosure of medical information, they may be permitted to re-disclose the information without my prior permission. Re-disclosure in such cases may not be limited by state or federal law.

I further understand that the Facility will give me a copy of this signed authorization.

I understand that I have the right to revoke this authorization, in writing, at any time before it ends. I also understand that my written revocation will not affect any disclosures of my information that the person(s) and/or organization(s) listed on the first page of this authorization have already made, in reliance on this authorization, before the time I revoke it.

I further understand that I am under no obligation to sign this authorization, and may refuse to do so. Except as permitted under applicable law, the Facility may not refuse to provide treatment or other health care services because of my refusal to sign.

Resident Signature:_____ Date:_____

Resident's Representative*
Signature:_____ Date:_____

* The Resident's Representative is authorized to sign for the resident because _____

_____.