Harbor Light
HOSPICE

# RELEASE OF MEDICAL INFORMATION

I hereby authorize Harbor Light Hospice to contact my physician(s), treating hospital, SNF and/or Home Health Agency to obtain information and/or records concerning my physical and mental condition and to release the following information to Harbor Light Hospice for the limited purpose of determining eligibility for hospice services and to provide continuity of care.

**Information Requested From:**

Name of MD, Hospital, SNF, Home Health Agency: ______________________________

Address: ______________________________

City, State, ZIP: ______________________________

Phone: ______________________ Fax: ______________________

**Patient Information:**

Print Name: ______________________________

Address: ______________________________

City, State, ZIP: ______________________________

Social Security Number: ______________________ Date of Birth: ______________________

**Information Requested:**

- ☐ History and Physical
- ☐ Insurance/Medicare/Medicaid Information
- ☐ Assignment of Benefits
- ☐ Medical Assessment
- ☐ Medical Plan of Treatment
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Consultations
- ☐ Operative Reports
- ☐ Other: ______________________________
- ☐ All of the above
- ☐ Pathology Reports
- ☐ Lab Reports
- ☐ Radiology Reports
- ☐ Social Worker Notes
- ☐ Nursing Notes
- ☐ Aide/CNA Notes
- ☐ PT Notes ☐ OT Notes ☐ ST Notes
- ☐ Chaplain/Spiritual Counselor Notes

**Send Information to:**

Name of Facility: ______________________________

Address: ______________________________

City, State, ZIP: ______________________________

Phone: ______________________ Fax: ______________________

Information to be released will not be further disclosed nor used for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by my legal representative or me. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and copy the information released. I further understand that refusal to consent to the release of information specified will prevent disclosure of such information to the hospice, and may result in the hospice being unable to establish eligibility to receive services.

This authorization is valid until ______________________ (not more than 2 years from today's date)

______________________ Patient Signature

__________ Date

______________________ Authorized Party Signature

______________________ Hospice Representative Signature

__________ Date

______________________ Relationship of Authorized Party

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