ESTD 1930
WILLAMETTE
MANOR
Assisted Living

Resident Name: (please print) _____

RELEASE OF INFORMATION – Health Care

I give consent to obtain or release any necessary information from my medical record or any healthcare facility or provider for continuation and coordination of treatment, payment, healthcare, or healthcare operations to Willamette Manor's Client Care Coordinator, Nurse, or Administrator.

INDIVIDUALS INVOLVED IN YOUR CARE:

Family, friends and caregivers are important to your care. Are there any individuals with whom you **DO NOT** wish us to discuss your care?

____NO ____Yes (Specify): _____

_____

PROTECTED INFORMATION

I understand and authorize the release of information pertaining to my diagnosis and treatment including drug and alcohol abuse, psychological and psychiatric impairments, and genetic and HIV-related information. This information shall not be disclosed to any person other than a physician, healthcare provider, or Willamette Manor's healthcare personnel.

CLIENT SIGNATURE

I have read and understand the information above, have asked questions about anything not clear to me, and am satisfied with the answers I have received. I understand I may revoke my consent in writing at any time, but action taken by Willamette Manor before revocation will remain covered by this agreement.

_____ _____
Resident Signature Date

_____ _____
Resident Representative Signature Date

_____ _____
Witness Signature Date