Authorization to Release Information

I hereby authorize the release of information from Southwestern Indiana Regional Council on Aging, Inc. (SWIRCA) of _____. This is to aid Case Management staff in arranging care from service providers in the community so that I may continue to live as independently as possible.

By signing this form, I am giving Southwestern Indiana Regional Council on Aging, Inc. (SWIRCA) permission to use/disclose information about my specific needs and desires in order to coordinate care.

____ Application

____ Eligibility Screen

____ Mental Health Assessment

____ Physician Certification for Long-Term Care

____ Intake Inquiry

____ Assessment for Combined Case

____ Case Notes

____ Health Care Provider Notes

____ Other (Specify) _____

_____

Those who many receive or disclose this personal information include*: (check all that apply)

____ Community Based Service Providers

____ SWIRCA Service Provider on your plan of care

____ Family/Friends (Specify) _____

_____

____ Doctors (Specify) _____

_____

____ Other (Specify) _____

_____

*Clients that do not allow release of information to service providers may reduce their ability to receive community based services. We will not otherwise condition your services upon signing this release.

It is the intent of SWIRCA, its employees and agents to maintain the confidentiality of your information and files. However, understand that those persons/organizations checked above may release personal information and may not be covered under the same privacy rules. In some circumstances, including treatment, court order, or allegation of abuse or neglect, SWIRCA may release personal information without your prior consent. For more detailed information, see your Notice of Privacy Practices.

I understand that I may revoke this permission at any time, which will stop release of personal information from the date the SWIRCA case manager receives my written request and thereafter. I also understand that it is my right to review any information contained in my file (except when limited by law) or information that is being shared with service providers. I understand that this consent is valid for one (1) year from the date that it is signed.

_____ _____

(Signature) Client or Personal Representative Date

_____ _____

(Print) Client or Personal Representative Authority of Personal Representative