Doulagivers®

ELDER CARE DOULA AND END OF LIFE DOULA

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:

's Privacy Officer to provide the client information:

Or their Designee

Name of individuals or organization authorized to receive the information:

- ☐ , Affiliates, and/or other
- ☐ Hospitals Any and all Doctors and/or Medical Staff:
- ☐ Rehab Centers/Nursing Homes:
- ☐ Assisted Living Facilities:
- ☐ Specific Physician:
- ☐ Specific Family Members:

- ☐ Others:

Specific information authorized for release: Any and all information, whether verbal or written pertaining to the client that deems pertinent to benefit in the medical and non-medical care planning for the Client named herein.

At the request of or purpose of release of information: To keep the clients physician(s) and /or family updated.

Expiration date for authorization: Upon cancellation of contract with the client.

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Statement of Understanding and Authorization:

1. I understand that I have a right to rescind this authorization by notifying the Privacy Officer in writing, and that if I do rescind the authorization, it will only affect release of additional information and not apply to information previously released.

2. I am fully aware that there is the potential for the authorized information to be subject to disclosure and re-disclosure by the recipient and in some cases will no longer be Protected Health Information.

3. I understand ☐ will or ☐ will not receive remuneration for releasing my Protected Health Information to the above-named party.

4. I understand that will not change my services or take any other action against me if I do not sign this authorization.

_____

Signature of Client or Representative Date

Printed Name Relationship to Client and Statement of Authority to sign for Client

_____

Signature of Witness Date

Printed Name

_____

Signature of Doula Date

Printed Name