

SUCCESS STORY

Authorization for Release of Information



Resident Name: _____ Date of Birth: _____

I authorize the use or disclosure of the above named individual's health information as described below. The following individual(s) or organization(s) are authorized to make the disclosure:

The type of information to be used or disclosed is as follows:

Success Story: To include my photograph, my diagnosis, summary of my condition, assist levels, care received and discharge status related to physical, occupational, or speech therapy during my stay in the facility.

The information identified above may be used by or disclosed to the following individuals or organization(s):

Name: Life Care Centers of America
Address: 3570 Keith St., NW; Cleveland, TN 37320

- ☐ Success Story to be posted to the facility bulletin board in a public area
☐ Success Story to be posted to the internet social media site(s) of this facility and/or Life Care Centers of America

This information for which I am authorizing disclosure will be used for the following purpose:

- ☐ Marketing purposes
☐ Other (please describe) _____
☐ The organization will receive financial or in-kind compensation in exchange for use or disclosure of the information. ☐ Yes ☐ No

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless I specify differently, this authorization will expire (*insert date or event*): _____

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

Signature of Patient or Legal Representative

Date

If signed by legal representative, relationship to patient _____

Signature of Witness

Date

Distribution of Copies: Original to provider, copy to resident/legal representative