NURSING & REHABILITATION CENTER

AN AFFILIATE OF MARTHA'S VINEYARD HOSPITAL, MASSACHUSETTS GENERAL HOSPITAL, & A MEMBER OF PARTNERS HEALTHCARE

ONE HOSPITAL ROAD · POST OFFICE BOX 1747 · OAK BLUFFS, MA 02557 · TEL: 508-696-6465 · FAX: 508-696-8004

Release of Information Form

Authorization Forms

Please print four copies of the **Authorization form.** These forms authorize Windemere to request medical records from doctors and/or hospitals on your behalf. **Please complete all four forms.**

Please ONLY fill out the applicant's name, date of birth, and social security number. The admissions person will fill out the rest of the form. **IF POSSIBLE PLEASE HAVE THE APPLICANT SIGN THESE FORMS.** If you are signing as the Health Care Agent, please include a copy of the Health Care Proxy and a written statement from an MD stating the Proxy has been invoked.

If you have a copy of the Durable Power of Attorney, that should be sent as well.

If you have any questions, feel free to contact us at **508-862-1951.** Thank you for your cooperation.

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Authorization Form

For the Release of Protected Health Information (PHI) to Windemere Nursing & Rehabilitation Center

Patient/Resident Name (Please Print) ____

Date of Birth ____________________________Social Security Number _________________________

By signing this Authorization Form, I understand that I am giving my authorization to WNR's designated medical record or database custodians to request my protected health information from the following person(s) or organizations(s) named below:

Name of Health Care Provider ____
Street Address/Mailing Address____
City, State, Zip Code ____
Telephone Number __________________________________ Fax Number _____________________

I specifically authorize the use and disclosure of the following PHI:
(Please provide a description of the particular date, such as doctor's notes, nurse's notes, etc. and period of time requesting):

____
____

The information to be used or disclosed pursuant to this authorization form may include information relating to behavioral and mental health observations, which are part of the medical record.

I may revoke this authorization at any time by notifying WNR in writing to the Medical Records Department P.O. Box 1747, Oak Bluffs, MA 02557 of my intent to revoke this authorization. A revocation form can also be obtained by contacting the Medical Records Department. However, I also understand that such revocation will not have any effect on any information already disclosed to WNR before WNR received my written notice of revocation.

Unless earlier revoked, this authorization on the 180th day of the signing or as otherwise specified below: ____
____
____

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If neither federal nor state privacy laws apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by privacy laws.
I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form. Please make such intentions clear to the Admissions/Medical Records Personnel when submitting this Authorization form.

The Authorization is voluntary and I may refuse to sign this form.
I understand that I am not required to sign this Authorization form in exchange for receiving treatment from WNR.

____ ___________________________

Signature of patient/resident or Durable Power of Attorney Date

____

Printed name of patient or resident

____

Printed name of Durable Power of Attorney (if applicable)