The Cheering Voices

HIPAA Privacy Authorization Form

(Required by The Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Resident's Name:
Facility:
Address:

Release of Information:

☐ I authorize _____ (healthcare provider) to release and disclose my protected health information described below to representatives of The Cheering Voices Ohio Nursing Home QI Project.

☐ I authorize the release of my complete health record including, but not limited to: medical diagnoses, date of birth, medication lists and usage records, cognitive examination results etc.

☐ This authorization for release of personal health information shall be in force and in effect until _____, at which time this authorization expires.

Signature of Individual or Authorized Representative **Date**

Print Name of Authorized Representative **Representative's Legal Authority to Individual**

cheering FOR CHARITY

513.827.ALZS (2597)
PO Box 53759 / Cincinnati, OH 45253
info@cheeringforcharity.org
cheeringforcharity.org

Benefiting those with Alzheimer's and their Caregivers