RESIDENT ACKNOWLEDGEMENT/ AUTHORIZATION

a) This is to acknowledge that I, _____, have received a copy of the following documents.

___ Resident Handbook
___ Services available to me as a resident of the Alpine House ("Facility")
___ Facility's Schedule of Fees
___ Concern/ grievance reporting procedure
___ Facility's Emergency Evacuation Plan
___ Resident Rights, Responsibilities and Residency Guidelines
___ Other:_____

Client/ Designee initials_____

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b) **I authorize the following use and/or disclosure of my Protected Health Information (PHI):**

___ To coordinate care with other healthcare providers involved in my care
___ For personal use, use by my attorney, and to communicate with insurance companies
___ For ongoing medical care, and services at the Facility
___ To set-up community resources such as PASSPORT, Hospice, Medical Supplies, Home Health, and/or other resources discussed with the facility
___ Other: _____

Client/ Designee initials_____

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c) **I authorize the following persons/ organizations to use and/or disclose my PHI to the Facility:**

___ Community resources specified in item b given above
___ All health care providers providing services to me
___Other:_____

Client/ Designee initials_____

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d) **I authorize the following persons/ organizations to receive and/ or use my PHI:**

___ Next of kin:_____
___ Primary caregiver:_____
___ Other family member(s):_____

Client/ Designee initials_____

e) **My right to revoke this authorization**: I understand that I have a right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing and that treatment or eligibility for my care is conditioned to on my providing this authorization except if such care is research related or provided solely for the purpose of creating protected health information for disclosure to a third party. To obtain a copy of an authorization revocation form, I may contact the Administrator of the Alpine House of Toledo at 2901 Tremainsville Rd., Toledo, OH 43613; Phone: (419) 724- 3671. I am aware that my revocation will not be effective if-

(i) This authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or policy itself, or

(ii) To the extent the person(s) and/ or organization(s) identified above have already acted in reliance upon this authorization.

I further understand that my personal information may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule.

_____ _____

Resident Signature Date

_____

Resident Name (Print)

Responsible Party

I, _____, am the resident's responsible party. The client is unable to sign due to the following impairment _____.

My relationship to the client is _____.

_____ _____

Responsible Party Signature Date

_____

Responsible Party's Name (Print)