VDSS MODEL FORM – ALF

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION
(See 22 VAC 40-72-570)

REGARDING: _____ DOB:_____ SS#:_____
(State full name of resident)

INFORMATION SOURCE (ALF name and address): _____

_____

INFORMATION RECIPIENT: _____
(Be as specific as possible regarding individual, title, agency and address)

_____

LIST INFORMATION TO BE DISCLOSED: _____

_____

_____

FOR THE PURPOSES OF: _____

This authorization is subject to revocation at any time, except when the information you authorized has already been sent. If not previously revoked, this authorization will terminate in __30 days __60 days __90 days __180 days __365 days or upon the following date, event or condition: _____.

Revocation is not effective until delivered in writing to the person in possession of my records.

This authorization will automatically expire upon my discharge from the assisted living facility.

If the above named recipient has requested specific confidential health information, I understand that my signature below provides written authorization for the release of that information. If my information contains information about substance abuse and/or communicable disease status, I authorize the ALF to release any pertinent substance abuse information and/or information relating to my communicable disease status including HIV/AIDS status.

This authorization includes information placed in my record after the date of my signature and before the expiration of my consent.

_____ _____
Signature of ALF Resident Effective Date of Consent

_____ _____
Signature of Legal Guardian or Legal Representative Effective Date of Consent