Please complete and return to Robland HHC

ROBLAND Home Healthcare Corporation

CONSENT FOR THE RELEASE OF INFORMATION

I, _____, hereby authorize
(Common Law Employer)

Robland HHC , Incorporated to exchange information with the following persons or agencies:

_____ County (please list) _____

_____ Department of Human Services

_____ Support Planner _____
(list name and/or agency)

_____ Other Providers (please list) _____

_____ Other (please list) _____

The following information may be exchanged:

_____ County ISP/Community Support Plan
_____ Physical and Medical History
_____ Physician's Orders
_____ Waiver funding and budget information
_____ Information from other Providers
_____ Other: Please List: _____
_____

I understand that my records are protected under State and Federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at anytime and that in any event this consent expires automatically as described below. I understand that information at Robland HHC is limited to staff whose work assignments reasonably require access to my data within the purposes specified in the services provided.

Date, event, or condition upon which this consent expires: _____ (max 1 year)

Executed this _____ day of _____.

Signature of Common Law Employer: _____

1500 1st Ave NE, Ste 111C
Rochester, MN 55904
Phone: 507-252-4619
Fax: 866-597-0950