Release of Information Form

Aging Safely Inc.
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Date Scanned: _____/____/20____

I _____ (name) authorize all medical providers to release medical

information for _____ (patient), born ___/___/___ (date of birth), to:
Dotti Snow, RN and associates of Aging Safely Inc. at the fax number above, by mail, or in person.

The purpose of this release of information is to aid in the placement of the patient into an Adult Family Home (AFH), or in completion of the Washington State nursing assessment required at the time of admission to an AFH, or change in condition of the patient while residing in an AFH.

I authorize the following information to be disclosed:

☐ Medical records ☐ Laboratory Values ☐ Pharmacy records ☐ X-ray reports ☐ DSHS records
☐ Health care information related to the following condition(s), treatment, or dates of treatment
_____
☐ I want to limit the records to be disclosed as follows: (by date, type of record, etc.)
_____

I give my permission to disclose the following records (check all that apply):
☐ HIV/AIDS and STD test results, diagnosis or treatment records (RCW 70.24.105)
☐ Mental health records (RCW 71.05.620) including: _____
☐ Chemical Dependency (CD) records (42 CFR Part 2) including: _____

I also authorize Dotti Snow, RN at Aging Safely Inc. to release these medical records to the qualified assessor selected to conduct the state-required Nursing Assessment.

I also authorize Dotti Snow, RN at Aging Safely Inc. to release any medical records obtained under this release to the selected Adult family Home, upon placement of the patient in that home.

I understand that I can terminate this release, by contacting Aging Safely Inc. in writing at the above address. This release will automatically terminate in 90 days.

Signed _____ Date ___/____/_____