



ACCESS TLC
Home Health Care

Home and Community Based Services (HCBS)

**AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION**

For the purpose of coordinating my healthcare and medical care needs, I, _____
by my signature below hereby authorize **Access TLC Home Health Care**, to obtain any and all of my
protected health information through electronic mail, fax, paper copies, digital/electronic records, and
Health Information Exchange (HIE).

THIS AUTHORIZATION CONTINUES TO BE VALID AND ENFORCEABLE UNLESS REVOKED IN WRITING.

I understand that by signing this authorization:

- *I authorize the use or disclosure of my individually identifiable personal health information as described above for the purpose listed.*
- *I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.*
- *I have the right to receive a copy of this authorization.*
- *I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.*
- *I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.*

Patient Name (print): _____ DOB: _____

Patient Signature: _____ Date: _____

Legal Responsible Party Signature: _____ Date: _____

Legal Responsible Party Relationship to Patient: _____

Vital Plus Home Health dba Access TLC Home Health Care
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