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) from any and all of the following health and medical service providers:

- **California Department of Social Services including but not limited to, In Home Support Services, and any and all Medi-Cal offices.**
- **California Department of Developmental Services including but not limited to Regional Centers.**
- **Any and all Hospitals, Physician/Medical Offices, Facilities, Mental Health Service Providers, and any other Medical Service Provider not already listed above.**

THIS AUTHORIZATION DOES NOT EXPIRE AND IS 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 understand that this authorization does not expire and that 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 I understand that this form is required in order to obtain my medical records necessary to be evaluated for eligibility criteria for Medi-Cal Programs.*
- *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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