

Authorization for Disclosure of Contact Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information.

Disclosure Authorization

By signing this Authorization for Disclosure of Health Information, I authorize the nursing home identified below to disclose my name, address, and telephone number, email address, or the contact information for my personal representatives/responsible parties to a health care plan so that health care plan(s) contracted with the nursing home identified below may contact me about their products and services.

Shaker Place Rehabilitation and Nursing Center

518- 869-2231

Nursing Home Name

Nursing Home Telephone No.

100 Heritage Lane

Albany

NY

12211

Nursing Home Address

City

State

Zip Code

I understand the following:

- My permission to disclose my contact information or my personal representative's contact information will expire one year from the date indicated below unless the nursing home identified above receives earlier written notification from me ending my permission to give my information to other parties. However, this will not effect any actions that have already occurred due to my original permission.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and sent to the nursing home identified above. My revocation will be effective upon receipt, but will not be effective to the extent that others have acted in reliance upon this authorization.
- My personal health information will be used only for the purposes outlined above.
- This authorization is voluntary. I may refuse to sign this form. I understand that my provider(s) may not condition treatment, payment, enrollment, or eligibility for benefits based on my refusal to sign this authorization.
- If my information is re-disclosed to a third-party who is not a health care provider or health care plan, or health care clearinghouse, it may not be protected by federal privacy laws.
- No other personal health information will be released to any third-party pursuant to this authorization.

Print Name of Resident

Medicare ID Number

Print Name of Authorized Representative

Signature of Resident/Member/Authorized Representative

Date

Email Address

If you are the authorized representative of the resident, you must provide the following information:

Relationship to Resident

Address

Telephone No.