Mirror Lake Senior Living Community Village

Authorization to Release Protected Health and Medical Information

Resident's Name:_____
Last First MI

Date of Birth:_____ Social Security Number:_____

Address:_____

Phone:_____ Clinic Number:_____

I hereby authorize:_____

To release the following medical information concerning myself/or:

_____

***Please FAX copies of current H&P and a list of current medications to:
Fax Number: 206-429-2766
Attention: Director of Wellness

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV, AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing and/or treatment.

_____
Signature of Resident and/or Resident's Authorized Party Date

_____
Relationship or Status if signed by anyone other than the resident

Senior Services of America Management, LLC