Sweet and Gentle Home Health Care Co.

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfiled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient. This authorization may be revoked by the patient at any time.

I hereby authorize [name of provider/address]:

_____

_____

To disclose from the health records of:

Name:_____
DOB:_____ SS #_____ Telephone #_____
Address_____

Covering the periods of healthcare (date(s) of services):

From (date) _____ to (date) _____

For the purpose of:_____
To disclose to [name/address]:_____

The following information may be released: (please indicate the type of records that may be released (i.e., clinical summaries, laboratory reports, nurses notes, or all medical records)

_____

Check and initial all that are applicable:
I understand that this will include information relating to:
_____☐ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
_____☐ Behavioral health service/psychiatric care
_____☐ Treatment for alcohol and/or drug abuse

If compensation will be revised: I understand that_____ will receive compensation for its use/disclosure of the information released pursuant to this authorization_____ (patient initials)

AFFIRMATION OF RELEASE

I give_____ or the named provider permission to release only the information I have selected on this form to the individual(s) or provider(s) I have named and only for the purpose I have check. I understand that this release is valid up to the expiration date stated below and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not effect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

_____ _____
Signature of Patient/Representative and relationship Date Signed

Expiration date:_____

Universal Home Healthcare, Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____

Med. Rec. No:_____ Start of Care Date:_____ Date of Birth:_____

1. I hereby authorize _____ to release to:

_____

_____

2. Information to be released:

___Clinical Records ___Daily Notes ___Other (specify):
___Evaluation ___Progress Notes _____
___Test Results ___Discharge Summary _____

3. The above information is released for the following purpose and the purpose only. Any other use is forbidden.

_____

_____

4. I also understand that I may revoke this authorization at any time.

5. This authorization will expire sixty (60) days from the date of my signature or as otherwise specified by date, event or condition as follows:

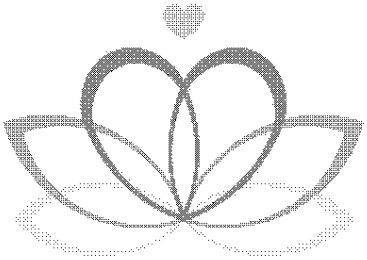
_____

_____

6. With respect to any mental health information that may be contained in the client's clinical records, I hereby waive my/his/her rights to the privileges of confidentiality.

_____ _____
Client Signature or legal representative Date

Relationship to patient_____ Witness Signature_____



A B A HOMECARE PROVIDERS

3900 NW 79TH AVE
SUITE 446
DORAL, FL 33166
305-594-2171 Phone
305-594-2172 Fax

MEDICAL RECORD RELEASE AUTHORIZATION

TO: _____

ADDRESS: _____

I hereby authorize and request you to release to: ABA HOMECARE PROVIDERS
3900 NW 79TH AVE SUITE 446
DORAL, FL 33166

The complete medical record in your possession, concerning my illness and/or treatment during the period from:

_____ to _____

Or

Record of specific result/information:

_____

_____

_____

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____

All American Home Health, Corp.

AUTHORIZATION TO RELEASE PATIENT INFORMATION

AUTORIZACION PARA LIBERAR INFORMACION DEL PACIENTE

Please complete this form in its entirety. Items not checked or blanks unfiled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient. This authorization may be revoked by the patient at any time. *(Favor de completar esta forma, partes no chequeadas o en blanco serán asumidas como no aplicables. No es válida si no tiene la firma del paciente y fecha de firmada, o si esta vencida como se explica abajo. Copia de esta forma se le dara al paciente, quien puede revocarla en cualquier momento.)*

I hereby authorize [name of provider/address]:*Yo autorizo (nombre/dirección del proveedor)*

_____

_____

To disclose from the health records of: *(a discutir los records de salud de)*

Name/*Nombre*:_____

DOB/*Fecha de nacimiento*:_____ SS #_____ Telephone #_____

Address/Dirección: _____

Covering the periods of healthcare (date(s) of services): *Cubriendo los períodos de cuidado de la salud de*

From/*Desde* (date) _____ to/a (date)_____

Por el motivo de:

For the purpose of:_____

To disclose to [name/address]:_____

A discutir (nombre/dirección)

The following information may be released: (please indicate the type of records that may be released (i.e., clinical summaries, laboratory reports, nurses notes, or all medical records) *(La información siguiente puede ser liberada (indique tipo de record (E): sumarios clínicos, resultados de laboratorio, notas de enfermeros, a todo el Record Médico):*_____

_____

Check and initial all that are applicable: *(Marque todo lo aplicable)*

I understand that this will include information relating to: *(Puede incluirse la siguiente información)*

□ Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection *(SIDA)*

□ Behavioral health service/psychiatric care *(Problemas de comportamiento/psyquiatricos)*

□ Treatment for alcohol and/or drug abuse *(Tratamiento de adicción/abuso de alcohol o drogas)*

If compensation will be revised: I understand that_____ will receive compensation for its use/disclosure of the information released pursuant to this authorization_____ (patient initials) *(Si se recibe una compensación, poner las iniciales)*

AFFIRMATION OF RELEASE/*AFIRMACION DE LA LIBERACION DE INFORMACION*

I give to name/provider_____ permission to release only the information I have selected on this form to the individual(s) or provider(s) I have named _____ _____ and only for the purpose I have check. I understand that this release is valid up to the expiration date stated below and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not effect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

Le doy permiso a _____(Proveedor de servicio), para que transfiera información autorizada por mi a _____ solo por lo autorizado por mi. Esta autorización solo es valida hasta la fecha de vencimiento señalada abajo, y puedo rechazar o revocar esta autorización en cualquier momento, sin perjudicar mi abilidad para obtener tratamien y/o pagos por los servicios que necesito. La revocación sera efectiva en la fecha que sea recibida por escrito. Como paciente tengo derecho a acceder a mi información médica, copia de los records puede ser obtenida a razonable costo por copias. Si la información es recibida por una organización no cubierta por las leyes federales de preservar la privacidad de la información, esta puede ser discutidas con otras entidades y no ser protegidas por regulaciones federales.

_____ _____

Signature of Patient/Representative and relationship — Date Signed

Firma del paciente/Representante/relación — *Fecha firmada*

Expiration date/*Fecha de vencimiento*:_____