HUALAPAI ELDERLY SERVICES (HES)

Release of Information

Client Name:	**DOB:**
By signing this authorization, you are giving the Hualapai Elderly Services permission to release all or part of your information provided, which includes health information. Failure to provide this authorization will result in limited service by the Hualapai Elderly Service Programs. This release includes access to a continuum of service(s) available through the HES or its providers.	

PARTS A, B & C TO BE COMPLETED BY CLIENT OR PERSONAL REPRESENTATIVE

I authorize the Hualapai Elderly Services to release my information to the following person or agency for the purpose(s) stated in Part A. My information will remain available to the person or agency indicated in accordance with the expiration event or date in Part B.

PART A – Release of Information
I understand that my information may contain protected health information. Release my information to the following person or agency: ☐ Any person or agency necessary to meet my service needs.
☐ Only the persons or entities identified:
Check one of the following: ☐ Release all of my information. ☐ Release only the following information:

PART B – Purpose of Release
☐ General: To assist in assessing, arranging, and meeting individual service needs.
☐ Specific:
☐ Expiration: This authorization expires at point of reassessment, where applicable, or within one year of effective date.

PART C – Signature	
(Client or Personal Representative)	*(Date)*
☐ Check if you are signing for the client and please describe your authority to act for the client on the following line:	
Note: If the person requesting the release of information cannot sign his/her name, two witnesses to his/her mark (X) must sign below. Accept one witness signature in circumstances where it is not possible to obtain two witness signatures. Document the reason in the client file.	
Witness:	Date:
Witness:	Date:

Notice to Client:

- ✓ Once the authorization to release your information is granted, the HES is not responsible for any redisclosure of the information by the recipient.
- ✓ You can withdraw permission you have given the HES to use or disclose health information that identifies you, unless the HES has already taken action based on your permission. You must withdraw your permission in writing.