Release of Information

For____

(name)

Financial

1. I give my OK for Choices In Community Living to release all necessary information requested by agencies that may provide me with financial assistance.

□ Yes □ No

Documentation/Information

2. I give my OK for Choices In Community Living to release insurance information, social histories, any and all medical information, incident reports, biographical data and other programmatic information to:

- **□ CICL Nursing (for the purposes of continuity of care, delegated medication administration, and health related activities).**
- **□ Adult Services**
- **□ County Board of Developmental Disabilities**
- **□ School**
- **□ Other_______________________________**

Transportation

3. I give my OK to ride in a vehicle driven by an employee or volunteer of Choices In Community Living.

□ Yes □ No

Media

4. I give my OK for my full name, photo and other identifying information to be used in print or other media as identified below. All pictures will be uploaded to a secure email and then deleted from personal devices.

- **□ Within Choices In Community Living**
- **□ "Choices Voices" newsletter (distributed through database and online on Partners For Community Living website)**
- **□ Feature story or news release to area media, public presentations**

□ Name and/or photo on Partners website (other than newsletter) and/or other social media, i.e. Facebook
□Name and/or photo for fundraising and/or solicitation for CICL and/or Partners For Community Living
□Can use quotes for CICL/Partners print or media
□I DO NOT give permission to use my picture for any reason
□I DO NOT give permission to use quotes

Healthcare

5. I give my OK for Choices In Community Living to release all necessary information requested by healthcare professionals as needed for medical treatment.

□ Yes □ No

6. I give my OK for Choices In Community Living to assist me in obtaining routine and emergency medical care.

□ Yes □ No

7. I give my OK for Choices In Community Living to assist me in selecting healthcare professionals. My preferences, if any, are:

Primary Doctor	
Dentist	
Hearing	
Psychiatrist	
Neurologist	

Vision	
Hospital	

______________________________________ ____________
Signature of Individual or Legal Guardian **Date**

______________________________________ ____________
Signature of Witness/Relationship of Individual **Date**

______________________________________ ____________
Choices Representative **Date**

Under the Law all Choices In Community Living Clients are protected through HIPAA.
By signing this form today, I understand that per HIPAA, no individual's personal or medical information will be shared with anyone outside of their team under any circumstances, due to HIPAA laws.
Please refer all questions or concerns to the Home Manager. You can also contact our HIPAA Compliance Officer, Chasity Cook, at (937) 898-2220.