Zen Hospice Project

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

It is the policy of the Zen Hospice Project to hold all information about clients as confidential and to not release information without permission. In order to facilitate your application process we need permission to contact your healthcare providers and to get information about your physical and mental health.

I, ____ (name), hereby give my permission to obtain or disclose my private health information for the purpose of admission to the Guest House residence. This authorization is valid for the duration of the intake process.

While it is your right to limit or exclude information from disclosure, this authorization is for full disclosure of all records, including diagnosis, treatment, assessment, dates of hospitalizations, mental health/psychiatric conditions, HIV/AIDS testing results, drug and alcohol information, and sexually transmitted disease information.

You may revoke your consent at any time.

You have the right to a copy of this authorization.

Your confidential information is protected by the Federal Privacy Act and California Law.

X ____ X ______________

Signature of Client or Representative Date