



PATIENT CONSENT FOR SERVICES
AUTHORIZATION FORM

PATIENT: _____ DATE OF BIRTH: _____

I authorize employees of Bayshore Health & Homemaker Services, Inc. to come into my residence and assist with my medical and/or personal care. I give my consent for skilled nurses employed by Bayshore to enter my residence, when necessary, for the purpose of supervising my care.

RELEASE OF INFORMATION

I authorize Bayshore to use or disclose the following health care information (check all that apply):

- checkbox All my health information maintained by Bayshore
checkbox My health information related to the following treatment or condition: _____
checkbox My health information for the date(s): _____

Bayshore may disclose this health information to:

- checkbox Healthcare providers checkbox Family checkbox POA, Guardian, Executor checkbox Trust Officer/Financial Advisor
checkbox Attorney

Reason for this authorization (check all that apply): checkbox At my request checkbox Other (specify) _____

This authorization ends: checkbox On (date) _____ checkbox Upon my discharge from Bayshore

PATIENT RIGHTS

I understand that I am under no obligation to sign this form and that Bayshore Health & Homemaker Services, Inc., who I am authorizing to use and/or disclose my health information, may not condition treatment, payment, or eligibility for health care benefits on my decision to sign this authorization. I also may inspect or copy the protected health information to be used or disclosed hereunder.

I also understand that I may revoke this authorization in writing at any time by sending such written notification to Bayshore at P.O. Box 1462, Largo, Florida 33779-1462. Such notice will not apply to actions taken by Bayshore prior to the date such notice or revocation is received by Bayshore.

I further understand that I have the right to lodge a complaint about Bayshore, or any other home care provider, without fear of discrimination or reprisal for having done so. I can do this by calling the state Abuse Hotline (1-800-962-2873) 24 hours a day. I also understand that I have the right to, and have received, information regarding Advance Directives, including a written description.

Bayshore's representative has answered my questions, provided assistance and allowed me to participate in my service plan.

I hereby also acknowledge that I have received a copy of Bayshore Health & Homemaker Services, Inc.'s Notice of Privacy Practices.

Patient or Legally Authorized Individual Signature Date: _____ Time: _____

Name if signed on behalf of patient

Relationship (Health Care Power of Attorney, Guardian, Personal Representative)

Agency Witness