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):

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

Bayshore may disclose this health information to:

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

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

This authorization ends: ☐ On (date)__________ ☐ 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.

______________________________ Date: ______________ Time: __________
Patient or Legally Authorized Individual Signature

______________________________ ______________________________
Name if signed on behalf of patient — Relationship (Health Care Power of Attorney, Guardian, Personal Representative)

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Agency Witness