VENTURE FORTHE
PERSONALIZED HOME CARE SERVICES

Authorization for release of health information pursuant to HIPAA

Extent or nature of information to be disclosed: Diagnosis, prognosis, recommendations regarding treatment, attendance, medical information, progress reports, discharge information and summary, results of any psychiatric/psychological consults, and financial information related to the provision of services provided by Venture Forthe, Inc to the undersigned.

*If additional information, please specify here:*_____

Information that is not authorized to be disclosed by this consent; specify here:

Purpose or need for the disclosure: To evaluate for appropriate treatment, aftercare follow up, accurate billing, and/or participation in the services provided by Venture Forthe, Inc. as required by the undersigned's service agreement, and at the request of the individual.

If additional purpose, please specify here: _____

Between (Name or title of person or organization): Venture Forthe, Inc.

And (Name or title of person or organization):

Primary Care: Specialist(s):

MCO (Insurance): Emergency Contact:

Health Home Care Manager: Other:

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained.

I, the undersigned, understand that Venture Forthe, Inc. cannot require me to sign this authorization to release information in order to receive treatment, services, or payment or to enroll or be eligible for benefits.

I, the undersigned, understand that information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations or state law.

I, the undersigned, understand that this consent may be withdrawn by me at any time by written notice to Venture Forthe, Inc's Privacy Officer. This consent shall expire 60 days after the termination of my services with Venture Forthe.

_____

(Signature of Client) (Date)

_____

(Print Name of Client) (Client Date of Birth / SSN (last 4)

_____

Name and Signature of Legal Guardian if applicable