Authorization to Obtain and Release Confidential Health Care Information

I _____ (printed name of Client or their Representative) authorize ***Alternative Options*** to Obtain and Release any written or oral Confidential Health Care Information (CHI) regarding _____ (printed name of the Client) to and from Providers (Including the Qualified Nurse Assessor and Nurse Delegator for the purpose of locating an appropriate Supportive Housing Community for the Client.

Information Obtained and Released may include (but not limited to):

1. Face Sheet, Care Plan, Psychological Reports, Discharge Plan, Lab Results, Treatment and After Care Plans, X-Ray/Imaging Reports Team Notes, Initial Evaluation or Assessment, Immunization Record, Court Documents, Evaluation & Recommendation, Consultation Reports or other.
2. Current Living Arrangement
3. Recent Medical History & Physical condition (H&P)
4. List of Medications
5. Medical Diagnosis, health concerns and the reasons for seeking care
6. Medication Administration requirements including Self-Medication Administration and Nurse Delegation (if needed)
7. Food & other Allergies
8. Significant known behaviors or symptoms that require special care
9. Cognitive/Mental Status, memory impairment
10. History of Depression or Anxiety
11. History of Mental Illness
12. Social/Physical/Emotional/Cultural needs
13. Functional ADL's; Eating, Toileting, Walking, Transferring, Positioning, Personal Hygiene, Dressing, Bathing, Sleeping Habits, Housekeeping, Laundry and Transportation.
14. Personal Preferences
15. Activities of choice

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16. Financial Sources, Social Security, Retirement, Pension, LTC Insurance, VA Disabilities, VA A/A, Real Estate, Life Insurance, Investments, other
17. Monthly Expenses, Medical Insurance, Doctor bills, other
18. Type of Long Term Care setting i.e. Independent Living, Assisted Living, Adult Family Home or other.
19. Other - as related to the referral to an appropriate Supportive Housing Provider

It is very important that we work openly and honestly together for the Clients sake and that all known information be revealed up front. Otherwise the placement may not be as accurate as the Supportive Housing Providers are expecting.

We take the protection of your Confidential Health Care Information seriously. We will need your signed Authorization to Obtain and Release your Confidential Health Information to Supportive Housing Providers that we will be personally contacting and visiting.

In order to properly assist you in your search, we may be required to share some CHI with the Supportive Housing Providers that we set up tours with. We will keep as much CHI private as possible.

Types of Communities to Receive/Release Confidential Health Information: (Check all that apply)

☐ Independent/Retirement Community	☐ Assisted Living Communities	☐ Adult Family Homes
☐ Secure Memory Care Communities	☐ Skilled Nursing Facilities	☐ Rehab Communities
☐ In Home Care	☐ Hospitals	☐ Resident/Relative

It is very important to us that we match your loved one to the right Community.

Alternative Options complies with the WAC and RCW governing Placement Services. For consumer complaints about a referral agency contact the Attorney General's office:

1-800-551-4636, 800 5th Ave. Ste. 2000 Seattle, WA 98104
https://fortress.wa.gov/atg/formhandler/ago/ComplaintForm.aspx

I acknowledge that I received, read and understand this Release of Confidential Health Information:

Printed name of Client: _____

Authorized Representative Signature: _____ Date: _____

Printed Name of Authorizing Representative: _____

Relationship to Client: ☐ Self ☐ Power of Attorney ☐ Representative ☐ Spouse:
☐ Guardian ☐ Guardian ad litem ☐ Other

This form can be returned to Alternative Options in one of the following ways:

1. Electronically sign a copy from the web site
2. Email a signed copy to: **info@alt-optns.com**
3. Fax a signed copy to fax number: **360.984.5713**
4. Mail a signed copy to: **7510 SE Evergreen Hwy, Vancouver, WA 98664**

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