Resident Consent for Use and Disclosure of Protected Health Information

Kalākaua Gardens

I hereby give my consent for Kalakaua Gardens to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Kalakaua Gardens describes such uses and disclosures more completely.)

I understand that my consent is required to authorize Kalakaua Gardens an Adult Residential and Memory Care Community, to use and disclose my personal health information for the treatment, payment, and health care operations. I understand that this consent will be kept in my medical chart.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Kalakaua Gardens reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kalakaua Gardens 1723 Kalakaua Ave. Honolulu, HI 96826 or email: thomas.eustace@kalakauagardens.com

With this consent, Kalakaua Gardens may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Kalakaua Gardens may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow Kalakaua Gardens to use and disclose my health records for the intent of residing at the community.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Kalakaua Gardens may decline to provide treatment to me.

Name of person(s) to whom this information is requested for move-in of facility

Resident Name(s) _____

Proxy or Power of Attorney _____

Specific Information Requested:

- ☐ Care Plan
- ☐ Medication Administration Record
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Activities Profile Assessment
- ☐ Additional Assessments, orders, notes deemed important for admissions
- ☐ Coordinated Services Orders (PT/OT/ST or other)
- ☐ Skin Report

_____

Signature of Resident or Legal Guardian Date

Print Resident Name _____

Print Name of Legal Guardian (if applicable) _____

Information can be sent to the following facility or physician of prospective resident.

Facility Name _____ Name of Physician _____

Phone _____ Fax _____

Address _____

Email _____