**P.O. Box 534, West Linn, OR 97068**
**Phone: (503) 780-7353 Fax: (503) 723-5678**
www.livingright.net

***Helping you make the best senior living decision for your situation is my number one goal. To achieve this goal, it is important we work honestly and openly together. I have outlined how I conduct my business and ask you to sign, acknowledging you understand and agree to these terms and conditions. Thank you.***

- A phone call or e-mail to Living Right starts the process. I will call you and ask details about your current situation.
- By signing this, you are authorizing the Living Right consultant to collect and share information from your healthcare providers, and any case managers working with the subject person.
- Health and financial considerations are discussed confidentially during this initial assessment and it is very important that all information regarding these topics are revealed. We will discuss what Senior Housing Options want to be considered and based on information and research decide which facilites want to be toured. If the family or resident has contacted facilities or another agency within the past three months it is important for Living Right to be told this information.
- Living Right will contact prospective facilitities and arrange for a convenient time for all of us to tour.
- The decision regarding facility choice is the resident's with family input. Living Right's role is that of a consultant. We will assist with helping the resident and family ask good questions and discerning information, but the final choice is that of the resident.
- When a choice is made—deposit and facility move-in procedures will be discussed with housing staff. Health and financial information will be requested by the housing provider. A health assessment which includes contact names and numbers, medical information, and necessary care be must conducted before moving into a licensed facility. Large communities have their nurse provide this information and the cost is covered in the move-in/entrance fee. This paperwork is important to provide good information about the resident to the entire staff at the residence and also to comply with state regulations for the facility.
- Payment to "Living Right Senior Placement" for services is provided through an agreement with the housing facility; therefore a resident, at the time of move-in, must be paying with private funds or long-term care insurance.
- Follow-up during the first month by Living Right will be conducted—it is the goal that the choice for senior housing was a good one for the resident, family and facility. Please stay in touch with Living Right, our relationship is an important one!

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# HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

**1. Authorization**: I authorize Living Right, Inc. to use and disclose the protected health information described below to prospective housing communities that would be appropriate options for me to move into.

**2. Effective Period**: This authorization for release of information covers healthcare information from all Past, Present and Future periods.
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**3. Extent of Authorization:** I authorize the release of my complete health record with the exception of the following information:
□ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify):
_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

5. This authorization shall be in force and effect until I terminate my agreement with Living Right, Inc. at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative

Printed name of Patient or Legal representative and their relationship to patient Date