GOLDEN YEARS
SENIOR CONCIERGE

HIPAA PRIVACY AUTHORIZATION

Authorization for Use or Disclosure of Protected Health Information

I _____ have hired Golden Years Concierge Service ("Golden Years") to perform certain senior concierge services for me. As such, I authorize Golden Years to receive and/or disclose my protected health information as outlined below:

- Golden Years is allowed to receive all medical information from any doctor, hospital, clinic or other person/facility who has provided medical services to me within the last year.

- Golden Years is allowed to disclose my personal medical information to parties that need this information to ensure my safety and health.

This authorization shall be in force and effect until the last day of service by Golden Years or when terminated by myself or my Responsible Party, at which time this authorization expires.

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. 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 Client or Power of Attorney Date

_____

Printed Name of Client or Power of Attorney

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