Keota Health Care Center

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Authorization for Access to Safekeeping Application

Resident Name Social Security Number Date of Birth

I hereby Authorize_____(the facility) to disclose my health information as described below.

Authorized Person: Please list the name and email address of the individual that will be allowed access to the safekeeping application.

Name email address

Information available in the Safekeeping Application will include the following items. These items will be released to the Authorized person listed above.

- Vital Signs (including pain)
- Medication
- Facility Information
- Events

Understandings & Agreements of Requestor

1. This authorization is voluntary and I understand that the facility cannot condition treatment based on the signing of this authorization, unless the authorization is (a) for research-related treatment, or (b) solely for the purpose of creating health information for the use or disclosure to a third party.
2. I understand that I may revoke this authorization at any time by notifying the facility in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
3. I agree to waive all claims against the facility for the release of the requested information.

4. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.

Signature of Resident/Resident Representative Date