AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Job #: _____
MR #: _____
ID Checked: Initials:_____

Information About the Use or Disclosure

I hereby authorize the use or disclosure of my protected health information ("PHI") as described below:

Individual's Name: _____
(Print or type full name)

Previous Name: _____ Date of Birth: ____/____/____

Address: _____ Day Phone #: (____) _____

City, State Zip: _____ Evening Phone #: (____) _____

Persons/organizations authorized to release the PHI:	Persons/organizations authorized to receive the PHI:
☐ Portage Health ☑ Upper Great Lakes ☐ Portage Health Medical Group ☐ Aspirus Clinics	Portage Pointe Name of Person/Organization to Receive PHI
500 Campus Drive Address	500 Campus Dr Address
Hancock, MI 49930 City, State, Zip	Hancock, MI 49930 City, State, Zip
Phone #: (906) 483-1556 Fax#: (906) 483-1536	Phone #: (906) 483-1300 Fax#: ( )

Information to be released (please check all that apply)

Hospital Records		Physician Office Records:	
Date of Service:		**Date of Service:**	
____/____/____	☐ ED	____/____/____	☐ Office Note
____/____/____	☐ Lab(s) Report	____/____/____	☐ Problem List
____/____/____	☐ X-ray(s) Report	____/____/____	☐ Lab(s) Report
____/____/____	☐ Operative Report	____/____/____	☐ Medication List
____/____/____	☐ Discharge Summary	____/____/____	☐ X-ray(s) Report
____/____/____	☐ Pathology Report	____/____/____	☐ Referral Report
____/____/____	☐ History & Physical	____/____/____	☐ Immunization Record
____/____/____	☐ Other (Specify)	____/____/____	☐ Other (Specify)
_____		_____	

I specifically mean this to include any information regarding HIV/AIDs, Drug or Alcohol use/abuse, Mental Health and other records in accordance with federal regulations. Please cross out any that do not apply.

Specific purpose of the disclosure (please check one): ☐ Continuing care ☐ Insurance ☐ Personal ☐ Legal
☐ Other: _____

This authorization will expire: One (1) year from the date of your signature below
(Indicate a date (e.g., December 31, 2017) or an event relating to the purpose of the authorization (e.g., "rejection of my life insurance application"))

Important Information About Your Privacy Rights

I have read and understood the following statements about my privacy rights:

* I may revoke this authorization at any time prior to its expiration date by notifying the Director of Medical Records in writing, but the revocation will not have any effect on any actions Portage Health took in reliance on this authorization before it received my revocation.
* I may request a copy of this signed authorization from the Medical Records Department.
* I am not required to sign this authorization in order to receive treatment.
* I understand there may be a fee to process this release of information.
* Information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer protected by the federal privacy regulations.

Patient's Signature_____ Date____/____/____

If not signed by patient, please indicate relationship:

(Please Circle One) Parent Legal Guardian Personal Representative

Print_____ Signature_____ Date____/____/____

PORTAGE HEALTH

PortagePointe ELDER ADMISSION APPLICATION

Name_____ Telephone_____

Address_____

Physician_____ Birthdate_____ Marital Status_____

Current Medical Conditions _____

_____

Does applicant have a Legal Guardian? ☐ Yes ☐ No

Name_____ Telephone_____

Address _____

Does applicant have a Durable Power of Attorney for Healthcare? ☐ Yes ☐ No

Name_____ Telephone_____

Address _____

Do you presently receive services from the system? ☐ Yes ☐ No

☐ Portage Home Health ☐ Portage Home Services ☐ Other_____

Other home care providers (home health, durable medical equipment, UPCAP):

_____

_____

Social Security Number_____ Veterans Claim Number_____

Medicare Number_____ Part A_____ Part B_____

Medicaid Number_____ Other Healthcare Insurance(s)_____

Person responsible for financial arrangements_____

Address_____ Telephone_____

Who should we contact about possible openings in our home?

1. Name_____ Home or Cell Phone _____

   Address_____ Work or Cell Phone _____

2. Name_____ Home or Cell Phone _____

   Address _____ Work or Cell Phone _____

Signature of person completing application_____

Relationship to applicant_____ Date_____

PortagePointe
FUNCTIONAL ASSESSMENT

Name: _____

Please put an "X" in all boxes that best describes you (the Elder).

	TOILETING		**COMMUNICATION**
	Alone		Has normal speech
	With supervision		Has impaired speech
	With assistance of one		Does not speak
	Is unable to do		Is able to write
	BOWEL FUNCTION		Language Spoken:
	Is continent		Is hard of hearing
	Is incontinent		Has a Hearing Aid ☐R ☐L
	Has accidents		**EATING AND FEEDING**
	Has an ostomy		Eats by him/her self
	Wears Depends		Needs supervision
	BLADDER FUNCTION		Needs assistance of one
	Is continent		Must be fed
	Is incontinent		Needs encouragement
	Has accidents		Is tube fed
	Has a catheter		Uses adaptive equipment
	Wears Depends		**THOUGHT PROCESS**
	VISION		Is clear
	Is normal		Is distorted
	Is impaired		Has problem with memory
	Wears glasses		Is able to make decisions

PortagePointe
FUNCTIONAL ASSESSMENT

Name: _____

Please put an "X" in all boxes that best describes you (the Elder).

	MOBILITY LEVELS
	Is able to walk:
	Alone
	With assistance of one
	Does not walk
	Climbs stairs alone
	Does not climb stairs
	Uses Brace
	Uses Prostheses
	Uses Walker
	Uses Cane
	Is able to turn in bed
	Is able to transfer out of bed/chair:
	Alone
	With supervision
	With assistance of one
	With a lift
	WHEELCHAIR
	Is able to wheel self
	Is pushed

	Care of Teeth/Mouth
	Is able to perform alone
	With assistance of one
	Is unable to do
	Has dentures ☐Upper ☐Lower
	Has no teeth
	Has own teeth
	Has a partial plate
	DRESSING
	Is able to dress self
	With assistance of one
	Is unable to do
	HAIR CARE
	Is independent
	With assistance of one
	Is unable to do
	TAKING A BATH
	Alone - without help
	With supervision
	With assistance of one

PortagePointe
FUNCTIONAL ASSESSMENT

Name: _____

Please put an "X" in all boxes that best describes you (the Elder).

	Wears contacts		Able to ask appropriate questions
	THOUGHT PROCESS (con't)		**TRANSPORTATION**
	Able to answer appropriately		Alone
	Can follows directions		Needs assistance
	Can make self understood		Is unable to do
	SHOPPING		**LAUNDRY**
	Alone		Alone
	Needs assistance		Needs assistance
	Is unable to do		Is unable to do
	COOKING		
	Alone		
	Needs assistance		
	Is unable to do		

Signature: _____ Date: _____

Signature: _____ Date: _____

PORTAGE HEALTH

Elder's Name: _____

Other Information Needed

Please provide us with a copy of the following information:

- ❑ Social Security Card
- ❑ Medicare Card
- ❑ Medicaid Card
- ❑ Medicare Part D Provider Card
- ❑ Any Other Insurance Cards

Have you had a flu shot this year? ❑ Yes ❑ No

Have you had a recent TB test? ❑ Yes ❑ No
Where? _____

What is your current living arrangement?

- ❑ Home
- ❑ With family
- ❑ Assisted living center
  Name: _____
- ❑ Other nursing home
  Name: _____