A Plus®
HOME CARE & HOSPICE

1443 North 1200 West, Orem UT 84057 · Phone: 801-228-0650 · Fax: 801-225-4067

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____ Social Security #: _____

I request and authorize *Crossroads Home Health & Hospice* to release healthcare information of the patient named above to:

Name: _____

Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Print Name (if POA) _____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED. YOU MAY ALSO REVOKE THIS AUTHORIZATION ANY TIME BY CALLING OUR OFFICE AT 801-228-0650.