Alzheimer's ORANGE COUNTY | MEMORY SUPPORT SERVICES

LINK TO MEMORY SUPPORT SERVICES

…partnering with families, health care and aging service providers to improve care and support for individuals with memory loss or cognitive impairment

AlzOC MEMORY SUPPORT SERVICES helps families and individuals with memory issues or cognitive impairment. Complete the form on the reverse to directly link families and individuals to free services which include:

- **consultation**, information, counseling and support
- a **person-centered** social assessment and care planning
- **educational** and **memory enhancement** programs
- help with **understanding and responding to memory loss**
- **planning for the future**
- linkage to **community resources including Healthy Aging Centers**

Additional questions?
Call: 844-373-4400

Complete the referral!

2515 McCabe Way, Ste. 200, Irvine CA 92614 | Helpline 844-373-4400) | www.alzoc.org

Link to Memory Support Services Alzheimer's | ORANGE COUNTY

Fax or email this form to: Fax # 949-757-3765 E-mail: arp@alzoc.org Or Call us at: 844-373-4400

AUTHORIZATION to Release and Exchange Patient Health Information

Patient's Name:_____Date of Birth: _____

Contact Person's Name:_____Relationship to Patient: _____

Contact Phone Number:_____Email: _____

I, the undersigned, hereby authorize (Physician/Pharmacist/Nurse/Social Worker/Case Manager)

_____ to disclose the following information to the **Alzheimer's**
(name of provider)

Orange County ("AlzOC"): My diagnosis and support needs.

I also authorize AlzOC to disclose to Provider periodic updates on the support services being provided, including dates of service and specific services provided.

Purpose: I understand that the information is being provided to facilitate my Provider's referral of services to AlzOC and to allow feedback related to those services from AlzOC back to my Provider.

Duration: This authorization shall remain in effect until the Patient ceases receiving services from the AlzOC or until revoked.

Revocation: I understand that I or my representative can revoke this authorization upon written request and that if I revoke, it will not affect information disclosed before the receipt of the written request.

Revocation should be sent to the following addresses and/or as set forth in the Provider's Notice of Privacy Practices: **Alzheimer's Orange County, 2515 McCabe Way, Irvine, CA 92614 and your**

Physician/Provider: _____

Redisclosure: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization. I understand that I have the right to refuse to sign this authorization and my Doctor/Provider will not condition my treatment on whether I provide authorization for the requested use or disclosure.

_____ _____ _____

Date Patient or Representative Signature If representative print your name and relationship

REFERRING PROVIDER: PLEASE COMPLETE Preferred Language of Family Caregiver:_____

Specific concerns and requests for this patient/participant:

_____

Please check as applicable: **Urgent** ☐ Safety / Behavior Concerns ☐ Adult Day Health Care ☐

Memory Loss Education ☐ Caregiver support information ☐ Mejorando la Vida de la Cuidadora ☐

Your preferred method of communication:

Fax# _____

Email _____

2.15.22