Sycamores Terrace Retirement Community
Authorization for Release of Medical Information

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.

I _____, give permission to Sycamores Terrace Retirement Community to **receive and disclose** protected health information **to and from** the following:

Emergency Medical Providers
Insurance Companies
Home Health Agencies
Hospitals
Nursing Home
Pharmacy
Physicians & Health Providers pertinent to my care
Power of Attorney or designated family member
Veterans Administration
Tennessee Department of Public Health
The State of Tennessee Tenn Care Division, and MCOs (Managed Care Organizations)

_____

Signature of Participant or Personal Representative Date

_____

Printed Name of Participant or Personal Representative

_____

Description of Personal Representative' Authority