DIRECT CONNECT!

AlzOC partners with families, healthcare and service providers to improve care and support for individuals with memory loss, cognitive impairment as well as adults in need of a safe and supportive environment.

Complete the form on the reverse to directly link individuals and families to support and services which include:

- **consultation**, information, counseling and support
- **person-centered** social assessment and care planning
- daily socialization and health care/*Adult Day Services*
- **residential** care options
- evidence based **memory enhancement** programs
- help with **understanding and responding to memory loss**
- **planning for the future** including decisions concerning end of life issues
- linkage to helpful **resources**

**HELPS** families care for loved ones with chronic health conditions

**CONNECTS** families to resources, information, day services and residential settings

**IMPROVES** care coordination & supportive networks

**SAVES** resources and lowers utilization of high cost services

Additional questions?
Call: 844-373-4400

Complete the referral!

2515 McCabe Way, Ste. 200, Irvine CA 92614 | Helpline 844-HELP-ALZ (844-435-7259) | www.alzoc.org
AUTHORIZATION to Release and Exchange Patient Health Information

Patient’s Name: ___________________________________________  Date of Birth: __________________________
Contact Person’s Name: ____________________________________  Relationship to Patient: __________________
City: ____________________________________  Zip: ____________  Email:_________________________________
Contact Phone Number: __________________________________

I, the undersigned, hereby authorize ___________________________________________ to disclose my diagnosis
and support needs to Alzheimer’s Orange County (“AlzOC”).

I also authorize AlzOC to disclose to the above named person 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 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  Adult Day Services  Placement issues  Resources
Memory Loss Education  Safety / Behavior Concerns  Caregiver support information

Your preferred method of follow-up from us: Fax# ___________________________________________

Email  ___________________________________________  Phone _______________________________________

2.12.2020