Alzheimer's | ORANGE COUNTY

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**

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

Referral to Support Services

Alzheimer's | ORANGE COUNTY

Download this form at: http://bit.ly/prffeb21

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: ________________

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

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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 ______________________________