

CONFIDENTIALITY FORM

I, _____, understand that my medical records and my current condition are confidential information. I authorize Rolling Hills personnel to give information about myself, my condition, and changes in my condition to the following people:

NAME & ADDRESS	RELATIONSHIP & PHONE NUMBER
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I, _____. understand that information pertaining to changes in my status are confidential. I authorize Rolling Hills personnel to give information about changes in my status (i.e. financial concerns) to:

NAME & ADDRESS	RELATIONSHIP & PHONE NUMBER
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I request that the rehabilitation center release my valuable to _____ when I am no longer able to manage my valuables or upon my death.

SIGNED: _____

DATE: _____