HERITAGE LAKES

Concierge Wellness

We're there when you need us

This Concierge Wellness program is executed by third parties Total Care Medical, PLLC and Fox Rehabilitation Management Services, LLC. This program offers services in coordination with Heritage Lakes staff and is endorsed by the Management of Heritage Lakes. All parties aligned for the joint purpose in delivering a higher caliber of comprehensive care to each resident in a way that was streamlined for the resident and their family. Total Care and Fox Rehab are providing separate services than Heritage Lakes. If you would like to take part in any of the services listed above, please fill out the Intake Form to enroll in our Concierge Wellness Program. We will not take payment directly from any resident, all services are reimbursed by Medicare and Major Insurance Providers.

*Please use the clickable form to fill out your records. After this is complete, please download and email them to **info@tcmedicalhome.com** or print your form and turn it to the Concierge Wellness Director at Heritage Lakes.

ENROLLING NOW

TotalCare
Your Medical Home

Medical Record Release Fo
Authorization for Use and Disclosure of Protected Health Information

Recipient Name (please print)

DOB | SSN #

Address | City | State | Zip

Email | Phone Number

INFORMATION TO BE RELEASED - COVERING THE PERIODS OF HEALTH CARE

From (Date) To(Date)

Please Check type of information to be released:

- ☐ Complete health records
- ☐ Diagnosis & treatment codes
- ☐ Discharge summary
- ☐ History and physical exam
- ☐ Consultation reports
- ☐ Progress notes
- ☐ Laboratory test results
- ☐ Radiology reports/ images
- ☐ Cardiac Imaging
- ☐ Photographs
- ☐ Discharge instructions
- ☐ Other

Purpose of Request:

☐ Treatment ☐ Request of patient ☐ Billing or Claims ☐ Other _____

Send/ Release Information:

Release to Name: _____ Release to Address: _____

Time Limit & Right to Revoke Authorization:

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Total Care. Unless revoked, this authorization will expire on the following date or event _____ or 180 days from the date of signature.

Re-disclosure:

I understand that I do not have to sign this authorization and my treatment or payment of services will not be denied if I do not sign this form unless specified above under Purpose Request. I can inspect or copy the protected health information to be used or disclosed. **I authorize Total Care to release the protected health information specified above.**

Signature: _____ Date: _____ Time: _____

Witnessed by: _____ Verified Via: ☐ Photo ID ☐ Matching Signature ☐ Other _____