FAX 212-294-8198

GOD'S LOVE WE DELIVER®

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A MEDICAL DOCTOR OR LICENSED PRACTIONER MUST FILL OUT, SIGN AND FAX THIS FORM

Medical nutrition therapy and meal delivery services are needed for:

PATIENT INFO

Date: _____

Name:_____DOB:_____Ph:_____Cell:_____

Address:_____

_____

LIMITATIONS

PHYSICAL LIMITATIONS REQUIRED: ☐ ***This person has NO physical limitations***

Client cannot stand for more than 20 minutes ☐ Client cannot walk more than 20 feet without resting ☐

Client has severely limited range of motion in arms and legs ☐ Client needs assistance ambulating outside ☐

With the exception of appointments, client's mobility is restricted to the home ☐ Client is bed bound ☐

COGNITIVE LIMITATIONS REQUIRED DEMENTIA & HIV+: ☐ ***This person has NO cognitive limitations***

Client is disoriented to place/time ☐ Client exhibits wandering ☐ Client exhibits impaired judgment ☐

Check here if individual has any mental or cognitive challenges: ☐ Explain: _____

Note: Clients with dementia must have a support system in the home to accept meals delivered by God's Love

MEDICAL DIAGNOSES

Primary Medical Diagnosis: _____Date of Dx:_____

ICD-9/ICD-10 code (s): _____Disease Stage (if applicable): _____

Current Medications/Treatments: _____

Additional Medical Conditions:_____Hgt:_____Wgt:_____Date_____

CD4 and Viral Load required for HIV+ diagnosis

Test	Value	Date	Test	Value	Date	Test	Value	Date	Test	Value	Date
CD4			LDL			Triglycerides			Tot Chol		
VL			HDL			HbA1C			Serum Glucose		

DOCTOR/REFERRAL INFO

If the client is deemed to be eligible for services based on their medical diagnosis and physical inability to shop and cook meals for themselves, the client is referred for meals and medical nutrition therapy for:

☐ **<3 months _____** ☐ **6 months** ☐ **1 year**

Medical Provider's Name: _____**Title:** _____**License #:** _____

Medical Provider's Signature: _____

Medical Provider Ph: _____**Fax:** _____**Email:** _____

Contact Name: _____**Ph:** _____**Fax:** _____

Email:_____**Agency/Hospital:** _____

Certification: **I hereby confirm that the information above is true and accurate.**

New York State Department of Health

HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV and NON-HIV Related Information

EVERYONE, REGARDLESS OF DIAGNOSIS OR MEDICAL CONDITION, MUST SIGN THIS HIPAA

I consent to disclosure of: ☐ My HIV Medical Information* ☐ My **NON**-HIV Medical Information**

This form authorizes release of medical information including HIV-related information. You may choose to release just your non-HIV medical information, just your HIV-related information, or both. Your information may be protected from disclosure by federal privacy law and state law. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potentially exposed to HIV.

Under New York State Law HIV-related information can only be given to people you allow to have it by signing a written release. This information may also be released to the following: health providers caring for you or your exposed child; health officials when required by law; insurers to permit payment; persons involved in foster care or adoption; official correctional, probation and parole staff; emergency or health care staff who are accidentally exposed to your blood, or by special court order. Under State law, anyone who illegally discloses HIV-related information may be punished by a fine of up to $5,000 and a jail term of up to one year. However, some re-disclosures of medical and/or HIV-related information are not protected under federal law. For more information about HIV confidentiality, call the New York State Department of Health HIV Confidentiality Hotline at 1-800-962-5065; for information regarding federal privacy protection, call the Office for Civil Rights at 1-800-368-1019.

By checking the boxes below and signing this form, medical information and/or HIV-related information can be given to the people listed on page two (or additional sheets if necessary) of the form, for the reason(s) listed. Upon your request, the facility or person disclosing your medical information must provide you with a copy of this form.

Information in the box below must be completed

Name and address of facility/person disclosing HIV-related and/or medical information:

Doctor's Name:_____

Medical Facility/Hospital:_____

Agency: God's Love We Deliver

Name of person whose information will be released: _____

Name and address of person signing this form (if other than above):_____

_____

_____

Relationship to person whose information will be released: _____

Describe information to be released: _____

Reason for release of information: _____

Time period during which release of information is authorized. From: _____ To: _____

Disclosures cannot be revoked, once made. Additional exceptions to the right to revoke consent, if any: _____

_____

_____

Description of the consequences, if any, of failing to consent to disclosure upon treatment, payment, enrollment or eligibility for benefits (Note: Federal privacy regulations may restrict some consequences):

_____

All facilities/persons listed on pages 1 and 2 of this form may share information among and between themselves for the purpose of providing medical care and services. Please sign below to authorize:

Signature:_____ **Date:**_____

*Human Immunodeficiency Virus that causes AIDS ** If releasing only non-HIV medical information, you may use this form or another HIPAA-compliant general medical release form.

Please complete the information on P.2

Provide information for each facility/person to be given general medical information and/or HIV-related information. Attach additional sheets as necessary. It is recommended that blank lines be crossed out prior to signing.

Name and address of facility/person to be given general medical and/or HIV-related information:

God's Love We Deliver

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify: List your organization here

Name and address of facility/person to be given general medical and/or HIV-related information:

Reason for release, if other than stated on page 1:

If information to be disclosed to this facility/person is limited, please specify:

The law protects you from HIV related discrimination in housing, employment, health care and other services. For more information call the New York State Division of Human Rights Office of AIDS Discrimination Issues at **1-800-523-2437** or (212) 480-2522 or the New York City Commission on Human Rights at **(212) 306-7500**. These agencies are responsible for protecting your rights.

My questions about this form have been answered. I know that I do not have to allow release of my medical and/or HIV-related information, and that I can change my mind at any time and revoke my authorization by writing the facility/person obtaining this release. I authorize the facility/person noted on page one to release medical and/or HIV-related information of the person named on page one to the organizations/persons listed.

Signature: _____ **Date:** _____

(Subject of information or legally authorized representative)

If legal representative, indicate relationship to subject: _____

Print Name _____

Client/Patient Number _____