[SENIOR CARE NORTHWEST, LLC] PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Senior Care Northwest (SCNW) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SCNW reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Josh Agee at SCNW.

With my consent, SCNW may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, SCNW may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards and patient statements.

With my consent, SCNW may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that SCNW restrict how it uses or discloses my PHI to carry out treatment, payment and healthcare operations. This practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to SCNW use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it SCNW may decline to provide treatment to me.

| Signed by: | |
|--|---|
| Print Patient's Name | Print name of Legal Guardian; if applicable |
| | |
| Relationship to Patient | |
| | |
| | |
| Signature of Patient or Legal Guardian | Date |

Patient/Guardian must be offered a signed copy of this authorization form