AUTHORIZATION FOR CARE AND TREATMENT

(This authorization must be signed prior to admission)

I, the undersigned patient in the Montana Veterans' Home nursing home, hereby authorize the Home physician (and whomever he may designate as his assistants), and the staff of the Montana Veterans' Home nursing home, to administer all care and treatment modalities necessary for my care and treatment while a resident of the Home.

I hereby certify that I have read and fully understand the above authorization for care and treatment. I also certify that no guarantee or assurance has been made as to the results or outcome of such care.

Applicant's signature _____ Date_____

Witness _____ Date_____

This authorization must be signed by the patient, responsible relative or legal guardian if appointed.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned patient in the Montana Veterans' Home, hereby authorize the Montana Veterans' Home to furnish such professional information, in accordance with the policy of the said facility, as may be necessary for the completion of my health care claims by the Department of Veterans Affairs (VA), and medical information contained in my medical record as necessary for the continuity of treatment and medical care from the medical records compiled during my patient stay in the said facility, and hereby release the Montana Veterans' Home from all legal liability that may arise from the release of the information requested. I also hereby authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or a related Medicare claim and request that payment of authorized benefits be made on my behalf.

Signature_____ Date _____

Witness_____ Date _____

This authorization must be signed by the patient, court-appointed legal guardian or agent.