Florida's Choice HEALTH CARE

Patient Choice Letter

Date: _____

Patient Name: _____

Date of Birth: _____

To Whom It May Concern

I, _____ understand in accordance with Medicare guidelines and HIPPA regulations that **I have a choice** to select my **Home Health Care or Skilled Nursing and Rehabilitation Providers.** I elect to use _____ for my home care needs. **AND/OR** I elect to use _____ for my skilled nursing and rehabilitation needs. I authorize _____to access my medical records.

Please discharge _____ Home Health Care; Effective _____.

Please discharge _____ Rehabilitation; Effective _____.

Patient/POA Printed Name/Phone Number: _____

Patient/POA Signature and Date: _____

Witness: _____

Thank you in advance,

Patient Signature:

_____