Aging Care ADVOCATES

CONSENT FOR RELEASE OF INFORMATION

Client Name: _____

Date of Birth: _____SSN:_____

I authorize the following parties:

_____

_____

(Doctors, Hospitals, Rehabilitation Centers, Medicare, Other Insurance Companies, Social Security Administration, Veterans Administration, etc.)

To verbally share and/or release copies of the information indicated below to **Aging Care Advocates, Inc.** and their representatives:

____ Medical Records and Reports

____ Psychological/Psychiatric Records

____ Tests and Evaluations

____ History and Physical

____ Discharge Summary

____ Financial Information

____ Other

I understand this information is necessary to evaluate, arrange, and coordinate services on my behalf and release the above named parties from liability for the exchange of information between themselves. This consent will be valid for a period of one year unless otherwise indicated.

Signature: _____Date: _____

Relationship: _____

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