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: ***(Please initial do not check)***

____ Medical Records and Reports

____ Psychological/Psychiatric Records

____ Tests and Evaluations

____ History and Physical

____ Discharge Summary

____ Financial Information

____ Photos (for our social media and marketing) ____ Photos for internal use only

____ Videos (for our social media and marketing) ____ Videos for internal use only

____ Testimonials (only using initials not full names for testimonials)

____ 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.

Signature: _____Date: _____

Relationship: _____

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