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

____ 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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