



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

_____ 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: _____