CONSENT to RELEASE INFORMATION

Name: ____

Address: ____

Phone*:* ______________________________

I authorize ____to release the following information about me:

Name, Address, Telephone Number ______
Date of Birth ______
Doctor's Name and Telephone Number ______
Contact's Name and Telephone number ______
Medical History ______
Treatments and Medications ______
Diet ______
Functional Abilities and Limitations ______
Service Plan ______

(Personal giving consent to initial each item he/she consents to.)

Information may be released to the following persons/agency/organization as specified:

1. ____ ________
2. ____ ________
3. ____ ________
4. ____ ________
5. ____ ________
6. ____ ________

(Person giving consent to initial each person/agency/organization listed.)

____

____

Signature of Person Giving Consent Signature of Witness

Date: ____________________________