Disclosure Authorization

Dedicated Care Solutions LLC Authorization to Disclose/Release Information

This form must be completed fully so requests can be processed

I authorize Dedicated Care Solutions LLC to disclose health, financial and personal information about:

_____ _____

Clients Name DOB

***The purpose of this disclosure is for senior housing and care service referrals.**
***I authorize Dedicated Care Solution's to review and discuss information obtained either verbally or in written format. This information may be shared via email, fax, telephone calls, electronic mailings and care planning meetings.**
***This release is valid for 90 days and may change with written notification of the client or their representative.**

By signing this form, I acknowledge that I have read and agreed to the terms on this form to *Authorize Dedicated Care Solutions to Disclose/Release Information*

_____

Signature (Client or Person Authorized) Date

If not the client print name, relationship and legal authority

Person/Company to receive the information for the purpose described:

Name:_____

Phone: _____

Address: _____