Dedicated Care Solutions

Consent to Release Health Care Information

Clients Name: _____

DOB: _____

I _____, as _____ hereby request the release of health care information from any long-term care facility, hospital, physician or other care provider and/or staff participating in the care to:

Dedicated Care Solutions at 621 SR9 NE PMB# D29, Lake Stevens, WA. 98258. Phone 425-737-3865 Fax 425-334-8910

This includes but it not limited to the release of all health care information, reports, photocopies, diagnostic tests and images, radiology reports, etc. That may be in your custody or control.

Dedicated Care Solutions and its staff are also authorized to disclose information relating to diagnosis and treatment to any health care provider or attorney in the care of the said named person.

I understand and authorize that this information may be release and provided in the following, but not limited to, telephone calls, care planning meetings, fax, mail, and electronic mail.

Dedicated Care Solutions reserves the right to change the terms of this disclosure with written notification to the client.

Photocopies are authorized and shall be valid as the original.

Signature of Client or representative Date