RELEASE OF INFORMATION

Client Name_____ Date of Birth _____

SSN# _____ Roll Number _____

I hereby authorize the exchange of confidential information between ElderCare Resources, Inc., and (list attorney, family and other non-medical entities):

Name _____ Relationship_____

Address _____ Phone_____

City _____ State_____ Zip Code _____ Email_____

Name:_____ Relationship_____

Address _____ Phone_____

City _____ State_____ Zip Code _____ Email _____

Name _____ Relationship_____

Address _____ Phone_____

City _____ State_____ Zip Code _____ Email _____

I recognize that the information disclosed may contain information that is protected by federal and state law, and I specifically consent to the same. This authorization expires the earlier of 2 years from date of execution or on _____.

_____ _____

Signature Date

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