2528-XXXX; expiring XX-XX-XXXX

IWISH Release of Information

I, _____ (name of resident), give my consent to the Resident Wellness Director and the Wellness Nurse to release my information for the purposes of helping to link me with programs, services, and benefits that will assist me in meeting my service needs and coordinating care to help me remain safely in my home. Only information that is necessary to help me secure the needed services or assistance may be shared.

I give my permission to share necessary information about me with the following individuals and/or organizations. (Check the boxes below to indicate with whom you are ALLOWING information to be shared and specify the agency name.)

☐ Family members (specify names)_____

☐ Physician Practices _____

☐ Pharmacies _____

☐ Hospitals _____

☐ Home Care or Home Health Agency _____

☐ Case Manager _____

☐ Area Agency on Aging _____

☐ Mental Health Agency _____

☐ Counselor or Therapist _____

☐ Veteran's Administration _____

☐ Social Security Administration _____

☐ Legal Services _____

☐ Other _____

☐ Other _____

This authorization is effective starting _____ and will remain in effect for the duration of IWISH until it expires on September 30, 2020.

I understand that I may revoke this consent at any time by signing the statement at the end of this document. The revocation will not apply to information that has previously been shared in agreement with this consent.

_____ _____

Resident name printed Date

_____ _____

Resident signature Date

I _____ (name of resident) revoke this release of information.

_____ _____

Resident signature Date