TOP AID
HEALTHCARE, INC

Authorization For Release of Medical Information

Please check one.

- ☐ Initial
- ☐ Annual

Date: _____

Patient Name: _____ DOB: _____

Patient Address: _____

I_____Hereby (Physician)_____To release to Top Aid Healthcare Inc, 69 Park Avenue Worcester MA 01605. All medical information is needed for the purpose of participation in the Adult Foster Care Program, which provides daily personal care services in my home.

I Understand

I have the right to revoke this authorization at any time, in writing. My revoke will not apply to information already obtained, used, or disclosed in response to this authorization. Information used or disclosed under the original authorization may be subject to re-disclosure and the recipient info will no longer be protected by federal privacy regulations. The information authorized by this release may include information related to mental health, drug/alcohol abuse and treatment records. As a result, by signing below I specifically authorize any such records included in my health information to be released.

The Person making the request is. ☐ The individual ☐ Someone else representing the individual:

Name of consumer: _____
Signature_____
Date sign: _____ Expiration Date: _____

If a person representative is making the request on behalf of the Consumer

Name: _____ Relationship: _____

Signature: _____ Date: _____