TOP AID
HEALTHCARE, INC
CARE FOR HUMANITY

Written Consent for Release of Information.

Client Name _____ DOB _____

Social Security Number _____

General consent:

I understand that information pertinent to my situation and best interest may be exchanged between Top Aid healthcare staff and other agencies or others involved with me while being evaluated for and /or participating in the Adult Foster Care Program.

_____ Client Initials

Medical Information

I hereby authorize any public or private custodian to release medical information, and records regarding my medical history and condition, or any history or current condition of communicable disease to the Top Aid Healthcare Adult Fister Care Program. I understand that Mass Health requires documentation from my medical practitioners, and ongoing communications between my medical practitioners and AFC staff.

_____ Client Initials

Financial Information

If I need financial assistance, I hereby authorize any private or public custodian of records to disclose to Top Aid Healthcare Staff any financial data or records needed to apply for financial assistance (usually SSI or Medicaid).

_____ Client Initials

Client Signature _____

Date Signed _____ Exp Date _____

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

Name _____ Relationship _____

Date Signed _____ Exp Date _____