

Authorization to Release Health Care Information

Client's Name: _____

Address: _____ City _____ State ____ Zip _____

Date of Birth: _____

Regarding the person named above, I HEREBY REQUEST AND AUTHORIZE (person and/or agency) _____

to release the following information

to Aging Well LLC
 Joan McGinnis, MSW, LICSW, GMHS
 114 2nd Ave S, Suite 109
 Edmonds WA 98020
 Phone: 206.571.049
 Joan@JoanMcGinnisMSW.com

In addition, I authorize Joan McGinnis to disclose information regarding care consultation and management services that she provides to me, to _____, in order to facilitate my optimum care.

This request and authorization applies to the following information:

Client Initial _____

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Signature of client or client's authorized representative Date Signed End Date

Relationship if signed by anyone other than client