ALPS Adult Day Services

Release of Information

By way of my signature, I provide ALPS (Alzheimer's Lakeway Program and Services) Adult Day Services with my authorization and consent to use and disclose protected information for the purpose of treatment and/or financial assistance.

participant name: _____ start date: _____

Social Security number: _____ date of birth: _____

caregiver signature: _____ date: _____

caregiver relationship: _____

****

I, _____, on behalf of the aforementioned participant, authorize ALPS Adult Day Services to do the following. I understand this authorization will remain in effect until I provide written instructions otherwise.

PLEASE CIRCLE YOUR CHOICE(S):

1. *ALPS **may** / **may not** call me at work.*
2. *ALPS **may** / **may not** leave a message for me at work.*
3. *ALPS **may** / **may not** release the participant's information to authorized physicians.*
4. *ALPS **may** / **may not** release the participant's information to authorized providers for possible financial assistance.*
5. *ALPS **may** / **may not** release the participant's information to the following person(s) or organizations*:

   name: _____ phone: _____

   name: _____ phone: _____

   name: _____ phone: _____

caregiver signature: _____ date: _____