

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I hereby authorize _____ to release and to receive
(Name of Homes Plus Provider)

confidential information regarding _____
(Name of Patient/Resident)

for the duration of my stay or until formally rescinded to:

(Name of Person or Persons) (Address)

(Name of Person or Persons) (Address)

(Name of Person or Persons) (Address)

(Name of Person or Persons) (Address)

(Name of Person or Persons) (Address)

(Name of Person or Persons) (Address)

SIGNED BY:

Resident or Resident's Agent

Date

Print Name

Telephone #

If Agent, Relationship to Resident