

**Resident or Legal Representative's
Authorization to Release
Confidential Information**

I hereby authorize _____
Name of physician, nurse practitioner, institution or other care provider

to provide information about issues pertaining to the care needs and medical
condition of _____
Name of patient or resident

to _____
Name of adult foster home or licensee

Street address of adult foster home

City _____ *State* _____ *ZIP code*

Adult foster home telephone number _____ *Adult foster home fax number*

Signed by:

Patient, resident or legal representative's signature _____ *Date*

Print name of patient or resident _____ *Telephone number*

If legal representative, relationship to patient or resident