

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:** _____