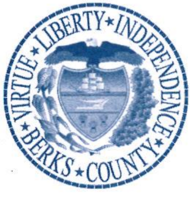

AUTHORIZATION FOR RECEIPT AND RELEASE OF INFORMATION OPTIONS & CAREGIVER SUPPORT PROGRAM

NAME OF CONSUMER: ____

WELLSKY ID__________________

I hereby authorize the Berks County Area Agency on Aging (BCAAA) to obtain/or release information relating to my medical, psychological, or psychiatric evaluation, financial circumstances, and social security status from or to those agencies from which I wish to receive services or benefits. It is understood that only necessary information will be supplied, and this information will be treated confidentially.

_____ I have been provided a link to or copies of the following forms that can be found at www.berksaging.org:

- County of Berks Notice of Privacy Practices
- County of Berks Notice of Health Information Organization and opt out information

_____ I have been provided a link to or a copy of Tower Health at Home's Privacy Practices that can be found at https://towerhealth.org/Notice-of-Privacy-Practices

_____ I have been advised of and provided a copy of the BCAAA's Notices and Disclaimers.

Consumer's Signature: ________________________________ Date: ________________

OR

Representative: ____ Date: ________________
(If applicable)

Relation to Consumer: ______________________________________

NOTE: Any photocopy of this document shall have the same force and effect as the original

County Services Center / 633 Court Street / Reading, PA 19601-4303
Tel (610) 478-6500 / Fax (610) 478-6886 / www.berksaging.org