RELEASE OF INFORMATION

By signing this form, I, authorize CODI to release verbal and written information as outlined below.

- I understand CODI cannot guarantee recipient of this information will not re-disclose information to a third party.
- I understand I may revoke this release in writing at any time.
- To revoke this release, please notify CODI's Director of Quality Improvement.
- CODI is not responsible for information released before revocation request.

I authorize CODI to release the information below to:

Name _____

Address: _____

City _____ State _____ Zip Code _____

I authorize CODI to release (check all that apply):

- ☐ Discharge Summary
- ☐ Service Plan
- ☐ Verbal discussion including information related to consumes services
- ☐ Medication Administration Record (MAR)
- ☐ Other:

I agree that my typed signature below will serve as electronic representation which will be in effect for six months from the date of signing unless otherwise noted.

Consumer Name Expiration Date

Consumer Typed Signature Date

Guardian Typed Signature Date