**Information Release Form**

The (Insert department name) would like to contact the local Aging and Disabilities Resource Center (ADRC) on your behalf. The Aging and Disabilities Resource Center (ADRC) wishes to provide assistance to you and your loved one so **you can safely remain in your home as you age**. The ADRC will work with you to get the resources you need to prevent further falls and to live safely in your home. The (Insert department name) will recommend the ADRC get you an in-home evaluation to provide you helpful tips to increase your home safety.

**The ADRC offers resources/programs related to:**

* **Transportation**
* **Nutrition**
* **Health Promotion and prevention**
* **Counseling**
* **Technology classes**
* **Dementia support**
* **Caregiver support**
* **Fall prevention**
* **Home Safety**
* **Resources related to your specific needs**

By signing this form, I authorize the (Insert department name) to release my name, phone number, address, and pertinent medical information pertaining to this 911 call that occurred on the date below to the local Aging and Disabilities Resource Center (ADRC). I acknowledge that the ADRC will contact me for further assistance. I acknowledge that refusal to sign this form is a refusal of my information being provided to the ADRC, and no information will be disclosed. I understand that the (Insert department name) giving out my personal information without my permission violates my HIPAA rights. I understand that prior to the ADRC receiving my information, I have the right to revoke my authorization by providing a written notice of revocation to the (Insert department name). This authorization expires in 90 days from the date signed.

**Name Printed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_**

**Witnessed by Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**