

Client Consent for Referral & Release of Information**Individual Being Referred:** Name: _____

Address: _____ Email: _____

Telephone: _____ Cell: _____

Physician's Information: Name: _____ Telephone: _____

Address: _____

Medical Diagnosis: _____**Type and Level of Service Needed:** _____**Primary Caregiver:** Name _____

Telephone: _____ Cell: _____

Emergency Contact: (If different than Primary Caregiver) Name: _____

Telephone: _____ Cell: _____

Reason(s) for Referral _____ and/or for Non-Admittance to Agency _____

_____ :

I authorize *SAFE LIFE HOME HEALTH CARE, LLC* to make a referral and release my personal information, as listed above, to the following person/agency/organization:

a. _____

b. _____

c. _____

(Individual giving consent shall initial next to each person/agency/organization to receive referral.)

Signature of Person Giving Consent_____
Signature & Title of Agency Representative**Date:** _____