



Berks County

Area Agency on Aging

Building Partnerships
Strengthening Communities
Enhancing Quality of Life

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 advised of and provided a copy of the BCAA's Notices & Disclaimers and Notice of Appeal Rights.

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