

# CHOICES FOR CARE PERMISSION FOR RELEASE OF INFORMATION

NAME: \_\_\_\_\_  
(print)

I give my permission for the Department of Disabilities, Aging and Independent Living (DAIL) Long-Term Care Clinical Coordinator to share information contained in my **Choices for Care** application and assessment with the Department for Children and Families, my legal representative, the local Waiver team, and all applicable **Choices for Care** program providers. In addition, I give permission to share with the following:

Family/Friend: \_\_\_\_\_

Physician: \_\_\_\_\_

Mental Health Agency: \_\_\_\_\_

Housing Provider: \_\_\_\_\_

Other(s): \_\_\_\_\_

Other(s): \_\_\_\_\_

Individualized Instructions (if any): \_\_\_\_\_  
\_\_\_\_\_

I understand that all information will be respected as confidential by these entities and that it will be used solely to facilitate **Choices for Care** eligibility determination, service coordination and program monitoring. I understand that if I decline to release information, it may affect my eligibility for the **Choices for Care** program.

I have read this **RELEASE OF INFORMATION**, and I agree to its terms as stated or amended. I understand that I may, at any time, revoke my consent to share any or all of the information by calling or writing the DAIL Long-Term Care Clinical Coordinator (LTCCC) listed below:

\_\_\_\_\_  
DAIL LTCCC Name Phone Number

\_\_\_\_\_  
*Individual or Legal Representative Signature*

\_\_\_\_\_  
*Today's Date*

Consent to share this information expires on \_\_\_\_\_ (no more than one year)  
date

**NOTE:** Mandated reporters are required by law to report suspected abuse, neglect or exploitation to VT Adult Protective Services (1-800-564-1612), with or without the consent of an individual.