

AREA AGENCY ON AGING

2120 Lakewood Drive, Suite B ♦ Coeur d'Alene, ID 83814
208-667-3179 ♦ 800-786-5536 ♦ Fax 208-667-5938

Ombudsman for the Elderly

AUTHORIZATION FOR RELEASE OF RECORDS

To: _____

Address: _____

I give my permission to release the following medical, financial and/or personal records and information concerning myself to the Idaho Ombudsman for the Elderly or the Ombudsman's designated representative for review and copying.

RECORDS/REQUESTS:

I understand that all information will remain confidential and will be used by the Ombudsman to assist me in resolving the complaint I have registered with the Ombudsman. The authorization is effective for sixty days from the date of my signature.

Signature of Complainant or Complainant's Legal Representative Date

Address of Complainant

Witness

Address of Witness