

## Release of Information Authorization

This is full and sufficient authorization to release/exchange client records regarding \_\_\_\_\_,  
(client name)  
 granted to both Caregivers Network of Minneapolis, Inc., and the following providers and/or companies for the purpose of providing safe and effective care:

Physician(s)/Physician Group(s)	Health Care Facility Hospital(s)
Physician(s)/Physician Group(s)	State Agency(ies) / Accrediting Bodies
Physician(s)/Physician Group(s)	Payor Source
Therapist(s)	School District(s)
Home Infusion Therapy Company	Home Medical Equipment Company (ies)
Pharmacy Store(s)	Utilities (Gas/Electric/Phone/Streets/Water)
Public Services (Fire/Police/EMS/Ambulance)	Past/Current Home Care Provider(s)
Other	Other
Other	Other

This authorization specifically includes, but is not limited to, records and/or information prepared prior to the date of this authorization and records and/or information prepared after the date of this authorization. Conversations between staff at Caregivers Network of Minneapolis, Inc. and others, including, but not limited to, physicians and others responsible for the care, discharge planning, financial planning, and general well-being of this client are also authorized by this release. These records will be handled in a confidential manner. A photocopy of this authorization will be treated in the same manner as the original. This authorization expires one year from the date it was signed, but may be revoked at any time by the client.

Signature of Client/Guardian	Relationship to Client	Date
Signature of Caregivers Network Representative		Date