PROTECTING
Quality Health Care,
NH Senior Advocacy Program

CLIENT RELEASE FORM

I, _____, hereby authorize
(name of client)

the staff of _____and Protecting Quality
(program name)
Health Care to act in my behalf in obtaining or releasing information about me to other agencies and individuals in negotiating for services or entitlements for me.

I understand that this information may be requested by, and shared with, governmental agencies which oversee programs supported by public funds and Protecting Quality Health Care.

_____
(signature of client)

_____
(date)

_____
(signature of staff)

_____
(date)

Valid for 6 months from signature date