Area Agency on Aging 1-B
Advocacy • Action • Answers on Aging

Consent and Release of Information

I am voluntarily participating in an assessment conducted by the Area Agency on Aging 1-B (AAA 1-B). The purpose of the assessment is to find out what services are required to help me remain independent. I agree to cooperate with the AAA 1-B staff who will work with me to get the services that will help me to remain independent.

I understand that:

— I do not have to answer any assessment questions that I do not want to answer.

— I can participate in the process for deciding the services that I am to receive. I understand that I will be informed when services are arranged on my behalf and notified of any subsequent changes made in these services, and that I have the right to appeal decisions regarding my care.

— I may be billed by the vendor if I fail to give 24-hour notice to cancel or reschedule services, except in case of emergency.

— I authorize AAA 1-B staff to contact my physician(s) to obtain protected health and other personal information from my medical file that may assist in developing my care plan, and I hereby authorize my physician(s) to release such information to AAA 1-B staff.

— I authorize AAA 1-B staff to contact service providers and that each of them may exchange and disclose to each other my protected health and other personal information that may assist in developing my care plan, or in addressing my emergency preparedness plan.

— I agree information from my assessment and care plan will be seen only by staff, consultants, and representatives of AAA 1-B, as well as service providers who may be directly serving me, although I acknowledge the personal information disclosed to such service providers by AAA 1-B is subject to re-disclosure by the former.

— I may withdraw from the AAA 1-B program at any time by informing the AAA 1-B verbally or in writing that I no longer want or need services.

— The program may discontinue or services may be reduced if program funds are significantly reduced or eliminated.

— This form and copies of this form operate as a release and authorization with respect to protected health information, valid for one year from the date of signing unless I revoke such release and authorization in writing to AAA 1-B.

— I have received and reviewed a copy of "Client Rights and Responsibilities" and, if appropriate, a copy of "Medicaid Waiver Beneficiary Rights and Responsibilities."

AAA 1-B staff have explained all of the above information to me. I understand that if I have questions, I should contact: **800-852-7795**

This Consent and Release expires: _____.
Date

_____
Participant's Name and Signature Date

_____
AAA 1-B Signature Date