CLIENT CONSENT FORM

FOR THE RELEASE OF CONFIDENTIAL INFORMATION

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I, _____ authorize:

(Client Name)

_____

(Name of agency and/or contact person)

_____

(Address of agency/contact person)

_____

(Phone number)

To disclose information to/from: NADAP Inc. Care Coordination Services Outreach/Referral

The following information:
Information necessary to make referral for Care Coordination Services

The purpose or need for such disclosure is:
To facilitate the referral process.

I understand that my records are protected under the Federal Health Portability and Accountability Act (HIPAA) of 1996, (42 CFR Part-160 &164), This protected health information cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

Specification of the date, event, or condition upon which this agreement expires: When I enroll in the program or choose to opt out of these services.

_____ _____

(Signature of client) (Date)