**A Nurses Touch Residential Care**

# Request for Release of Information

I, _____authorize
(Name of Person Giving Consent)

_____
(Name of individual, agency, or facility to whom disclosure is requested)

to release requested medical records to A Nurses Touch Residential Care for the purpose of continuing medical treatment and plan of care. This authorization for the release of information will remain on file. I understand the need for this request and have the right to revoke the consent at any time.

_____ _____
(Signature of person giving consent) Date

_____ _____
Witness Signature Date