Consent for Release of Information to Residential Care Providers From Unyeway, Inc.

I _____________________ authorize Unyeway, Inc.
(self or conservator)

to release information pertaining to _________________.
(Consumer's Name)

Information To Be Released:

Medical, Psychological, Payroll/P&I, Assessments/Evaluations conducted by Unyeway, Inc. or Consultants of Unyeway, and Individual Program Plan information and progress.

____________________________________ __________
Signature of Consumer or Conservator **Date**

Authorization becomes invalid one year after the date of Signature.

If You do not wish information to be release please fill out below

_____ No Information May Be Released to anyone listed

_____ All Information may be release except _______________________.

_____ All Information may be released except to ____________________.

Authorization becomes invalid one year after the date of Signature

____________________________________ __________
Signature of Consumer or Conservator **Date**