arrangeCARE
Elder Care & Special Needs
Case Management

Professional Consent

I hereby authorize Care Managers Leah Cohen, LCSW, CCM and Ina Picarello BSN, RN of arrangeCARE PC to be permitted to review and obtain copies of my medical and other related records, and to discuss pertinent information with professionals involved in my medical care.

This authorization is valid for one year after the date signed unless revoked by the signee.
I agree that a photocopy of this authorization be accepted.

_____ _____
Signature Date

_____
Self/Title

_____ _____
Printed Client Name Date of Birth

8127 Mesa Drive • Suite B206 • PMB 317 • Austin TX 78759
Phone: 512-814-3228 Fax: 512-243-6262 EIN 80-0320807
www.arrangecare.com