



arrangeCARE
Elder Care & Special Needs
Case Management

Professional Consent

I hereby authorize Care Managers Leah Cohen, LCSW, CCM, Ina Picarello BSN, RN, and Ramona Brush, BSW, NMG, TCG 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