Housing Stabilization Services Authorization To Release Information

Client Name: _____

Client Date of Birth: _____

Client Address: _____

Phone Number: _____

Email: _____

Effective Date: _____

Expiration Date: (indicate a date or check the box below this line)_____

☐ This release form does not expire until case closure or until services end.

Signature: _____ Date: _____

I, _____, hereby authorize **PARAGON CARES**, and its designated staff, to disclose to and request information from the following parties:

Emergency Contact First and Last Name:_____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Legal Guardian: _____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Target Case Manager First and Last Name:_____

Agency name:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Waiver Case Manager First and Last Name:_____

Agency name:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Care Coordinator First and Last Name:_____

Agency name:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Primary Care Doctor or Physician First and Last Name:_____

Hospital/Clinic name:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Health Care Directive:_____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Power of Attorney:_____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Other:_____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Other:_____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Other:_____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Other:_____

Relationship:_____

Contact number:_____

Email:_____

Address:_____

Fax:_____

Purpose of the Disclosure:

The purpose of this authorization is to allow PARAGON CARES to coordinate care and services related to my health, safety, and housing. This may include discussions about my physical and mental health, housing needs and preferences, safety concerns, and any other necessary items to assist in the provision and coordination of housing stabilization services.

Information to be Disclosed:

- ☐ Health records and status
- ☐ Housing status, records, coordination, and other needs related to housing
- ☐ Criminal Background Checks
- ☐ Credit Checks
- ☐ Care plans/Support plans
- ☐ Other:

Right to Revoke:
I understand that I have the right to revoke this authorization at any time by providing written notice to PARAGON CARES. However, I understand that the revocation will not affect any actions already taken by PARAGON CARES based on this authorization prior to receiving my notice of revocation.

Signature of Client: _____ Date: _____

I, _____, hereby authorize **PARAGON CARES**, and its designated staff, to disclose and request a credit and/or background check.

If the client is unable to provide consent, a legal guardian or authorized representative must sign below:

Name of Legal Guardian/Authorized Representative: _____

Relationship to Client: _____

Signature: _____ Date: _____