Alpine Fireside Health Center

"Family Taking Care of Family"

I _____, hereby authorize _____
Resident — Facility, Doctor's Office, Clinic, Hospital, Person, etc.

to release any and all requested information regarding:

- ☐ Medical Records
- ☐ Financial Information / Statements
- ☐ Dental Records
- ☐ Other (Specify) _____

to Alpine Fireside Health Center, Ltd. I understand I may revoke this consent at any time and I have the right to inspect all information disclosed to the facility.

_____ _____
(Printed Name) (Date)

_____ _____
(Resident's Signature) (Date)

_____ _____
(Printed Name) (Date)

_____ _____
(Resident Representative-POA) (Date)

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