Ohio Long-Term Care Ombudsman

Written Consent to Access and Disclose Confidential Information

Client's Name: _____ Place of Residence: _____

To identify, investigate, and resolve complaints related to my care, treatment, and/or rights, I authorize Representatives of the State Long-Term Care Ombudsman's Office to (*initial all that apply*):

_____ Disclose my identity and pertinent information about me, and to speak with friends, family, facility staff, and anyone else (including managed care plans) that may have relevant information, *except* as stated below.

_____ Discuss my complaint and reveal my identity to regulatory agencies conducting investigations or surveys prior to the expiration of this consent.

_____ If necessary, access and make copies of my medical, social, and financial records to assist in the resolution of my complaints, *except* as stated below.

Exception(s): _____

_____

_____

I further permit my long-term care provider to discuss any and all aspects of my care and treatment with a Representative of the State Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman Program is authorized by OAC 173-14-16 to request the aforementioned information.

This authorization is effective from the date of signature and shall expire upon resolution of this complaint, unless otherwise revoked by Client.

_____ _____

Print (Client *or* Legal Representative) Date

_____

Signature (Client *or* Legal Representative)

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