

Sycamores Terrace Retirement Community Authorization for Release of Medical Information

I, _____, authorize the release of all my medical information to healthcare providers including:

- Physicians pertinent to my care**
- Hospitals**
- Home Health Care**
- Nursing Home**
- Emergency Medical Providers**
- Pharmacy**
- Insurance Company**
- Power of Attorney or designated family member**

This will take effect on ____/____/____ and end on ____/____/____.

Signature