

This is a release of information agreement allowing the individuals/groups listed on this document, and Love INC Staff, to communicate about our mutual client in order to better serve and provide for their needs.

Coordination of Care

Love In the Name of Christ, 3300 Van Buren, Hudsonville, MI 49426 P- 616.662.3300 F- 616.662.2850

Love INC CLIENT(S) Name: _____ Date _____

Choose one:

- I **am not** being required to attend the LOVING HELP Budget Program
- I **am** being required to attend the LOVING HELP Budget Program by an
 - Church Individual Organization Agency
 - List name: _____

Please check **only one** option below that applies (Please note: initials required on items 1 or 3):

Option 1:

I agree that responses** may be provided to **any** individual/church/agency/organization that inquires about my involvement with Love INC and/or my LOVING HELP Program participation and resources received from Love INC and/or participating network churches. **Client initials:** _____

Conditions of Authorization (if any) *may include individuals you wish Love INC not communicate with:*

Option 2:

I hereby authorize **Love In the Name of Christ** to obtain information** from, and/or, release confidential information **ONLY** to the following person(s), agency(ies), organization(s) or church (s):

Options 3:

I **do not** wish **ANY** information to be provided to any individual/church/agency/organization that inquires about my involvement with Love INC. (Please note if someone does contact Love INC inquiring about your participation, Love INC staff will contact you requesting permission to speak with that person/ agency/ church/organization. An updated Coordination of Care form will be requested if permission is granted.) **Client initials:** _____

***Information shared will include, but not be limited to- attendance records (past and present), homework completion, items/services received from Love INC or Love INC ministries/donations, interaction with volunteers and staff.

I understand that I may withdraw my consent to release information in written form to the Love INC staff person listed below at any time. Love INC reserves the right to disqualify you from the LOVING HELP Program at any time if the information disclosed to us is not accurate or is proven to be false. We will discuss with you any discrepancies or concerns raised by information obtained by the service providers listed above before making a decision to disqualify. *This form will be provided to the persons/agency/organization/church in which you give Love INC permission to communicate.*

_____	_____
Client Signature	Date
_____	_____
Client Signature	Date
_____	_____
Third Party Witness Signature	Date
_____	(616) 662-3300 x
Love INC Staff person	Phone

