

# RELEASE OF INFORMATION

**By signing this form, I authorize CODI to release verbal and written information as outlined below.**

- I understand CODI cannot guarantee recipient of this information will not re-disclose information to a third party.
- I understand I may revoke this release in writing at any time.
- To revoke this release, please notify CODI's Chief Information Officer.
- CODI is not responsible for information released before revocation request.

I authorize CODI to release the information below to:

Name **Guillermo A. Gutierrez, MD**

Address: **1612 Chanticleer**

City: **Cherry Hill** State: **NJ** Zip Code: **08003**

I authorize CODI to release (check all that apply):

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Discharge Summary

Service Plan

Verbal discussion including information related to consumes services

Medication Administration Record (MAR)

Other:

I agree that my handwritten or electronic signature below will serve as authorization to release information and will be in effect for one year from the date of signing.

-----  
Consumer's Name (printed)

-----  
Consumer Signature

-----  
Date

-----  
Guardian Signature

-----  
Date