STATE OF ALASKA

DEPARTMENT OF REVENUE
Alaska Mental Health
Trust Authority

BILL WALKER, GOVERNOR

Office of the Long Term Care Ombudsman

3745 Community Park Loop. Suite 200
Anchorage AK 99508
Phone (907) 334-4480
Fax (907) 334-4486

Consent for Ombudsman Involvement and Authorization for Release of Information

Resident Name: _____ **Date of Birth:** _____
Address: _____ **Phone:** _____

_____ (initial) **I consent to have the Alaska Long Term Care Ombudsman advocate on my behalf regarding resident rights issues and good care practices.**

_____ (initial) **I authorize the Alaska Long Term Care Ombudsman to share my information with other agencies and/or providers if needed to advocate on my behalf.**

_____ (initial) **I authorize a representative with the Alaska Long Term Care Ombudsman to obtain information and records necessary to advocate on my behalf.**

_____ _____
Resident or Legal Guardian Signature **Date**

(Check one if signed by legal representative) ☐ **POA** ☐ **DPOA** ☐ **Guardian**

Legal Representative Name: _____

Phone: _____

Email: _____

CONSENT/AUTHORIZATION REVOCATION

I no longer want my information shared.

_____ _____
Resident or Legal Guardian Signature **Date**