Brave Heart Volunteers
yee gu.aa yáx x'wán

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

RELEASE OF INFORMATION

I authorize the exchange of medical and other information both verbally and in writing which is necessary for coordination of care, including volunteer matching, and referrals for support services between Brave Heart Volunteers and the following individuals and organizations:

My family and/or caregiver(s)	Sitka Pioneer Home
My physician	Swan Lake Senior Center
My pharmacy(s)	SAIL
Sitka Community Hospital	Center for Community
SEARHC/Mt. Edgecumbe Hospital	Other:

NOTE: The signer may cross off any individual(s) or organization(s) listed above, provided it does not basically change the intent of the form.

Client or Legal Representative Signature: _____

Date: _____

PHOTO RELEASE

I grant permission to Brave Heart Volunteers staff and volunteers to take photographs of me in connection with Brave Heart Volunteers services. I authorize Brave Heart Volunteers to copyright, use and publish the same in print and electronically.

I agree that Brave Heart Volunteers may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, fundraising, and web content.

Client or Legal Representative Signature: _____

Date: _____