AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION AND/OR TESTIFY AT A DEPOSITION, COURT HEARING OR TRIAL

I authorize representative(s) of the _____
Name of Long-Term Care Ombudsman Program
to disclose confidential information contained in the Long-Term Care Ombudsman records of
_____ either by providing copies of the records or by testifying
Name of Long-Term Care Resident
at a deposition, court hearing or trial.

Information disclosed may include the resident's identity, the identity of the resident representative (if applicable), written and electronic records, and/or other investigative documentation held by the Long-Term Care Ombudsman Program.

This authorization is effective immediately and will remain in effect until the legal proceedings have ended.

_____
Signature of Resident or Resident Representative *(if applicable)* **Date**

_____
Print Name of Resident or Resident Representative *(if applicable)*

Basis for Resident Representative's Authority (if applicable)**:**

- ☐ Designated Agent through an Advance Health Care Directive
- ☐ Designated Agent through a Power of Attorney
- ☐ Court-appointed Guardian or Conservator
- ☐ Spouse or Registered Domestic Partner
- ☐ Next-of-Kin
- ☐ Executor
- ☐ Court-appointed Personal Representative
- ☐ Other: _____

Submit this form, along with documentation to verify authority to represent the resident to the local LTCOP.