Care Coordination Consent

I, (Print Name) _____, hereby consent to receive any of the following services from AID Atlanta, Inc.: Case Management, Mental Health/Counseling/Emotional Wellness Services, Research, Education and Development (RED) Institute programs and services, Patient Benefit Services, Medical Services, and/or any other services as determined by me and my AID Atlanta Representative. I consent to allow my providers within AID Atlanta, Inc. to share relevant information and documentation for the coordination of my care.

I also authorize AID Atlanta to contact me, my legal guardian, and/or my designated emergency contact person, when appropriate, using the following methods:

To Contact Me:

Telephone: ❑ Yes ❑ No
Letter: ❑ Yes ❑ No
Email: ❑ Yes ❑ No

To Contact My Legal Guardian (if applicable)/ Designated Emergency Contact:

Telephone: ❑ Yes ❑ No
Letter: ❑ Yes ❑ No
Email: ❑ Yes ❑ No

Emergency Contact Name: _____ **Relationship**: _____

Contact Address: _____

Phone #: _____ **Aware of Status?** ❑ Yes ❑ No

Member Signature: _____ Date: _____

Staff Signature: _____ Date: _____