



Authorization for Release of Client Information

I, _____ give my permission for the Platte County Senior Fund (PCSF) staff to release any information deemed necessary regarding my medical condition and/or limitations to:

The Platte County Emergency Response Team Data List

as administered by the Platte County Sheriff’s Department and Local Police and Fire Departments in the event of an emergency.

Client Signature

Date

Witness Signature

Date

Mail to: Platte County Senior Fund
11724 NW Plaza Circle, #600
Kansas City, MO 64153

Client Address: _____

Client Phone #s: _____

Medical Concerns: _____