



• *Investigating concerns* • *Connecting to choices* • *Advocating for better care* •

AUTHORIZATION TO INVESTIGATE AND REVEAL IDENTITY

I, _____
(Circle all applicable: Self, Family Member, Durable Power of Attorney for Health Care, Durable Power of Attorney for Finances, General Power of Attorney, Legal Guardian, Other _____)

For _____
(Name of Resident/Consumer)

Authorize the Long Term Care Ombudsman to investigate my concern regarding:

(Name of Provider: Facility, Agency, Hospital, Other _____)

I further authorize the Long Term Care Ombudsman to disclose my identity in attempting to resolve my concern and acknowledge I am willing to speak with Ohio Department of Health surveyors if requested.

I understand this authorization will expire **one year** after the date of my signature or until withdrawn.

A copy of this authorization shall have the same effects as the original.

(Signature) Date: _____

(Address)

Email

2800 Euclid Avenue, Suite 200 • Cleveland, Ohio 44115 •
• 216.696.2719 • 1.800.365.3112 • Fax: 216.696.6216
www.ltco.org • info@ltco.org
Serving Cuyahoga, Geauga, Lake, Lorain, and Medina Counties