



BRAIN INJURY COALITION OF GREATER CLEVELAND

Informed Consent/Release of Information

Name: _____

Address: _____

Date of Birth: _____

I have been informed about the Brain Injury Coalition and understand that the purpose of this non-profit organization is merely to provide advice and guidance, in an attempt to empower survivors of traumatic brain injury and their families, to identify and access comprehensive, quality services in order to lead to greater independence.

I further understand that I have been made no promises, assurances, or guarantees as to the success of obtaining this goal and hereby waive all actions, if any, which could or may arise against the Brain Injury Coalition, its individual members or the organizations that they represent.

I authorize _____
to release information to the Brain Injury Coalition for the purpose of problem solving, to assist me in community reintegration. I understand that the information may be discussed beyond that group.

The release of information will expire in one year from this date, unless I request in writing, termination prior to that date.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Contact Information:

Marcie Moss Helfgott, Theodore J. DeCarlo,
Co-Chairpersons
Phone: (216) 448-6283
helfgom@ccf.org or DECARLT@ccf.org

Our mission is to serve as a link to community supports and service for survivors of acquired brain injuries and their families.