Personal Accounting Services, Inc.
Part of the AssuranceSD Family

PARTICIPANT RELEASE OF CONFIDENTIAL INFORMATION AUTHORIZATION FORM

Instructions: Please review, complete and sign at the bottom. Submit the form to PAS via one of the following options:

Mail or Drop-Off
20500 Eureka Road, Ste 112
Taylor, MI 48180

Email
HR@PASselfdirection.com

Fax
734.206.1433

This form authorizes PAS (Personal Accounting Services, Inc.) to disclose any information regarding the services you receive, wages and payment information for your workers and/or anything else related to your service and support plan. You have the right to revoke this Authorization by providing PAS with written notice of revocation.

AUTHORIZATION

I, _____, hereby authorize PAS or any of its staff to disclose, by any acceptable means, information regarding the services I receive, wages and payment information for my direct care professionals, including fax or email, and/or anything else related to my service and support plan described as follows:

I, _____, hereby authorize the release of the above information to the following person:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

This authorization does not grant the individual authority to sign off on timesheets or any other program-related documents.

Participant or Legal Representative Name: _____

Participant or Legal Representative Signature: _____

Participant Date of Birth: _____ Form Completion Date: _____