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	**Email**	**Fax**
20500 Eureka Rd, Ste 112 Taylor, MI 48180	HR@PASSelfDirection.com	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 Direct Care 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 Workers, 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:

Full Name

Address | City | State | Zip

Phone Number

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 | Date

Participant Date of Birth | Form Completion Date