Ombudsman
Expect Excellence in Your Care

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I understand this authorization will expire **one year** after the date of my signature or until withdrawn.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

_____Date: _____
(Signature)

_____
(Address)

Email

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