

**Rainbow Health Kare, Inc
2321 P Street
Sacramento, California 95816
(916) 983-1446**

RECIPIENT AUTHORIZATION RELEASE FORM

Date: _____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____

City: _____ **State:** _____ **ZipCode:** _____ **County:** _____

Medi-Cal: _____ **DOB:** _____ **Phone:** _____

SSN: _____

Giving Permission: I give permission for (*check appropriate box*):

____ (*share*) the person/organization and the agency above to share the listed information

____ (*release*) the person/organization above to release the requested information to the above agency.

Recipient/Guardian Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____

**Provider Name: Rainbow Health Kare Inc.
Contact Person(s): Pang Houa Vang or Alex Vang
Phone: (916) 983-1446
Provider Number: 1043497647**