☐ Geriatric & Adult Psychiatry, L.L.C
60 Washington Avenue, Suite 203
Hamden, CT 06518
Phone: 203-288-0414
Fax: 203-288-3655

☐ Geriatric Assessment Center
435 Danbury Road
Wilton, CT 06897
Phone: 203-761-1015
Fax: 203-288-3655

AUTHORIZATION TO RELEASE or OBTAIN MEDICAL RECORDS

Subject to the statements printed below, I, the undersigned patient or legal representative, hereby authorizes **Geriatric & Adult Psychiatry, LLC** and/or **Geriatric Assessment Center** to use or disclose health information, including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and HIV related information regarding:

Name of Patient: _____ Date of Birth: _____

Geriatric and Adult Psychiatry, LLC has my permission to release or obtain my medical records from

Provider's Name: _____
(MD/ PsyD/APRN/ PA/ LCSW/ MSW/ LMFT)

Provider's address: _____

Phone number: _____ Fax number: _____

Information to be released:

- Most recent history and physical examination
- Diagnosis, laboratory information
- Current medications and dosages
- Other information deemed relevant to my medical and psychiatric care

The purpose of this disclosure is for medical and psychiatric care.

I understand that I may revoke this authorization at any time by providing written notice to **Geriatric & Adult Psychiatry, LLC and/or Geriatric Assessment Center** and it will not have any effect on actions that Geriatric & Adult Psychiatry, LLC and/or Geriatric Assessment Center took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. This release form is valid for one year of the signature date.

Signature: _____ Date: _____

If signed by the Legal Representative, indicate your relationship to the patient below. Documentation to verify your authority must be provided.
Conservator____ Executor of Estate____ Power of Attorney____ Guardian____

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PERSONAL RELEASE OF INFORMATION

AUTHORIZATION TO RELEASE or OBTAIN MEDICAL RECORDS

Subject to the statements printed below, I, the undersigned patient or legal representative, hereby authorize **Geriatric & Adult Psychiatry** and/or **Geriatric Assessment Center** to use or disclose health information, including, if applicable, information relating to the diagnosis or treatment of mental illness to any names listed below who are **personally involved in my care.**

Patient Name: _____ DOB: _____

The Geriatric Assessment Center has my permission to speak with:

1. Name: _____ Relationship: _____
(Spouse/Child/Caregiver)

Primary #: _____ Other #: _____

2. Name: _____ Relationship: _____
(Spouse/Child/Caregiver)

Primary #: _____ Other # : _____

Information to be released:

- Financial information: ___Yes ___No
- Medication questions or changes: ___Yes ___No
- Permission to speak with my clinicians regarding medical care: ___Yes ___No
- To call on my behalf to cancelled or reschedule appointments: ___Yes ___No

The purpose of this disclosure is for medical and psychiatric care.

I understand that I may revoke this authorization at any time by providing written notice to **Geriatric & Adult Psychiatry** and/or **Geriatric Assessment Center** and it will not have any effect on actions that Geriatric & Adult Psychiatry and/or Geriatric Assessment Center took before it received the revocation.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

Signature_____ Date_____

If signed by the Legal Representative, indicate your relationship to the patient below. Documentation to verify your authority must be provided.

Conservator____ Executor of Estate____ Power of Attorney____ Guardian____