Geriatric and Adult Psychiatry, LLC

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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** 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

*ONE YEAR OF CLINICAL HISTORY ONLY.

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 G.A.P. Clinical Care & Research Center, LLC, but if I do, it will not have any effect on actions that G.A.P. Clinical Care & Research Center, LLC 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____