Geriatrics Planning & Solutions, Inc.
Arun S. Rao, MD
153 Valmore Court
Pennington, NJ 08534
Phone: +1 (267) 567-2138
Fax: +1 (267) 282-3849
Website: https://www.geriatricsplanningandsolutions.com
Email: info@geriatricsplanningandsolutions.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient-
Name::_____

Date of Birth:_____

Patient Address:_____

Patient Phone Number:_____

Patient Email:_____

Guardian/Legal Representative-
Name/Status (POA, Guardian, Next of Kin) _____

Address:_____

Phone Number:_____

Email:_____

Geriatrics Planning & Solutions, Inc.

Arun S. Rao, MD

Authorization for Release of Medical Records

I hereby authorize any health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, or family member who has cared for me to release my requested medical records to:

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Requested Medical Records:

- ☐ Patient histories
- ☐ Progress notes
- ☐ Test Results
- ☐ Radiology & Other Studies
- ☐ Consults
- ☐ Other:

I understand that my medical record may include on or more of the following (check all that apply):

- ☐ Treatment of communicable diseases, including sexually-transmitted diseases, tuberculosis, or hepatitis
- ☐ Treatment related to AIDS/HIV
- ☐ Mental health treatment or psychological conditions
- ☐ Alcohol or substance abuse treatment
- ☐ Genetic Testing
- ☐ Other:

The above person/organization, its employees, representatives, and any other persons performing services for them or on their behalf, may need to obtain, use, or disclose any and all information about my physical and mental health, including, but not

limited to, services for preventative, diagnostic, and therapeutic care, tests, counseling, and medical prescriptions for the purpose of (Check all that apply):

- ☐ Change of doctor
- ☐ Individual request
- ☐ Workers compensation
- ☐ Specialist referral
- ☐ Insurance purposes
- ☐ Continued treatment
- ☐ Legal Investigation
- ☐ **Other: Review for medical consultation**

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for (check/specify one below) ____ following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information. :

- ☐ ____ Days
- ☐ ____ Months
- ☐ ____ Years

By my signature below, I acknowledge that any prior agreement I have made to restric or lmit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____	_____	_____
Patient's Signature	Patient's Name	Date
_____	_____	_____
Guardian/Legal Representative's Signature	Guardian/Legal Representative's Signature	Date