ELDERConsult
GERIATRIC MEDICINE
Housecalls + Education

Authorization to Release Medical Information

Patient's Name: _____ Patient's Date of Birth: _____

Date of Agreement: _____

Health care regulations require that the interdisciplinary health team work under the orders of the participant's personal physician(s). Participant information is shared with personal physicians and other care providers as required by law.

ElderConsult strives to provide the highest quality of care to our clients. In order to do so, we consult with participant's families, physicians, insurance companies and other community professionals. In all cases, the purpose of these consultations is to enhance services to our clients. All professionals are bound by the guidelines of their professions to protect the participant's confidentiality.

In order for us to release information that you have shared with ElderConsult or to exchange information with parties other than your personal physician, your specific authorization is required.

Please choose **ONE** of the following choices:

☐ I agree to give ElderConsult staff permission to receive and share information relating to my current situation and condition to caregivers, health and social service providers and/or emergency contacts. This information is for the purpose of improving the services which I receive and may be written or verbal.

OR

☐ With the exception of information shared with my physician(s), I do not agree to give the ElderConsult staff permission to share information, verbal or written, relating to my current situation and condition, for the purposes of improving the services which I receive.

If confidential information is requested or needed from individuals not mentioned above, written permission to release specific information will be requested from the participant at that time.

Responsible Party's Name: _____ Date: _____

Responsible Party's Signature: _____