AUTHORIZATION TO OBTAIN NEEDED INFORMATION

I grant Geriatric Solutions permission to obtain all medical information (which may contain medication history, confidential HIV/AIDS related information, communicable disease related information, information relating to mental health and/or alcohol/drug use) that any healthcare provider or agency may have on record for the purpose of further medical care Information to be requested:

☐ History and Physical ☐ Discharge Summary ☐ Pathology Reports ☐ Physician's Progress Notes
☐ Radiology Reports ☐ Operative Reports ☐ Laboratory Reports ☐ All of the above

☐ Other (specify) _____

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Revocation must be in writing.

This authorization will expire automatically twelve months from the date on which it is signed.

I understand that I am under no obligation to sign this form. I am not signing this form to ensure receipt of healthcare treatment.

Signature _____ ☐ Patient ☐ Legal Representative Date _____

Legal Representative Name (print) _____ Relationship to Patient _____

Reason patient unable to sign: ☐ Lacks decision-making capacity ☐ Unresponsive
☐ Other _____

Office Use Only

Signature of Witness (GS employee) _____ Employee ID _____ Date _____

Phone consent of legal representative if he / she is not present to sign at the time of admission

Phone number called _____ Date _____

Legal Representative Name (please print) _____ Relationship to Patient _____

Reason patient unable to sign ☐ Lacks decision-making capacity ☐ Unresponsive ☐ Other: _____

Signature of Witness No. 1 (GS employee) _____

Employee ID _____ Date _____

Signature of Witness No. 2 (GS employee) _____

Employee ID _____ Date _____

Patient Name _____ Patient ID _____

GERIATRIC
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A program of Hospice of the Valley