GERIATRIC ASSESSMENT, MANAGEMENT & SOLUTIONS, LLC

Authorization to Release Information

Geriatric Assessment, Management & Solutions, LLC

Care Management & Professional Fiduciary Services

I authorize and direct any medical professional, hospital or other medical care organization, social services organization, pharmacy, governmental agency or insurance company to provide Geriatric Assessment, Management & Solutions, LLC or their agent(s) upon presentation of the original or a photocopy of signed authorization, any medical, mental health or social service information concerning the client named below. I understand that information obtained by Geriatric Assessment, Management & Solutions, LLC will be utilized to develop a plan of care for the benefit of the client named below.

I further authorize Geriatric Assessment, Management & Solutions, LLC to release information obtained pursuant to the development and implementation of a care plan for the client named below to others as deemed necessary for the development and implementation of the plan. In making this authorization, I expressly waive all rights under the Privacy Act and the Freedom of Information Act as to the furnishing of this information.

Client/Patient (printed)____

Date of Birth____/_____/_____

Signature of Client/Patient____________________________________ Date________

Or: Person with Legal Authority to sign on Client/Patient's Behalf

Name (printed)____________________________________

Relationship______________________________________

Address and Phone ____

Signature of Authorized Person _________________________________ Date _______

This consent is valid for five years or until otherwise specified or revoked.

Care Management specializing in dementia and mental health needs