AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

_____ I authorize Priti Gujar MD or Staff of Geriatric Treatment Resources LLC, to release any or all information concerning my medical care to the following individuals.

_____ I do not authorize Priti Gujar MD or Staff of Geriatric Treatment Resources LLC, to release any or all information concerning my medical care.

Patient Signature	Date
Print Name	Date of Birth
RELEASE INFORMATION TO	
Print Name	Relationship to patient
Print Name	Relationship to patient
Witness	Date
Primary Care Physician (If applicable)	Phone
	Fax
Pharmacy Name	Phone
	Fax