# SUBURBAN GERIATRICS

## Medical Record Release Authorization

To: _____

(Physician or Hospital)

_____

(Address)

I hereby authorize and request you to release my medical records to:


**Suburban Geriatrics, Inc.**
**2901 Jolly Road**
**Plymouth Meeting, PA 19462**
**P: (610) 272-3222 F: (610) 272-5655**

www.suburbangeriatrics.com

email: sg@suburbangeriatrics.com


Please forward any x-rays, lab results and reports of special studies (such as MRI, CT scans, Doppler, etc.) for the time period indicated below. I understand that I am giving you consent to use and disclose my healthcare information to carry out treatment, payment activities and healthcare operations. This release shall remain in effect for two years from the date of the signature below. I understand that I may revoke this authorization in writing at any time to the healthcare provider, but this will not affect disclosures made prior to the written revocation.

**FOR THE LAST 2 YEARS**

Patient Name: _____

Date of Birth: _____

Address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____