



## Bayshore Geriatric Solutions, Inc.

9270 Bay Plaza Blvd, Suite 604, Tampa, FL 33619

Office (813) 246-4120 Fax (813) 246-4194

### CONSENT FOR RELEASE OF INFORMATION

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

I authorize the following parties:

\_\_\_\_\_

(Doctors, Hospitals, Rehabilitation Centers, Medicare, Other Insurance Companies,  
Social Security Administration, Veterans Administration, etc.)

To verbally share and/or release copies of the information indicated below to **Bayshore Geriatric Solutions, Inc.** and their representatives:

\_\_\_\_\_ Medical Records and Reports

\_\_\_\_\_ Tests and Evaluations

\_\_\_\_\_ History and Physical

\_\_\_\_\_ Discharge Summary

\_\_\_\_\_ Financial Information

\_\_\_\_\_ Other

\_\_\_\_\_

\_\_\_\_\_

I understand this information is necessary to evaluate, arrange, and coordinate services on my behalf and release the above named parties from liability for the exchange of information between themselves. This consent will be valid for a period of one year unless otherwise indicated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_