Golden Rule Family Practice®

Healthcare the way *you* want it.

AUTHORIZATION

For Disclosure of Protected Health Information

I, _____, born _____, social security number _____, residing at _____; hereby consent to the disclosure of information from my medical records and authorize the release of records by:

Provider: Golden Rule Family Practice

I authorize the above entity to disclose any and all information from my records and to release my entire chart and record, including, but not limited to Summaries; History and Physical examinations; Operative Reports; Progress Notes; Lab Results; Cardiac Catheterization; X-Ray Reports and Diagnostic Tests, including films; Outpatient Records; Emergency Room Records; Trauma Flow-Sheets; Nurses Notes; Consultation Reports; Billing Statements and Insurance Claim Forms; and any an all other records from _____ (DATE) to the present. I further authorize any physician, clinical staff or administrative personnel of the above entity to provide information regarding the contents of these records. This disclosure and release of records is to be made to the following:

Provider: _____

Address: _____

_____

I fully understand the following: My medical record and/or other information in connection with the hospitalization/treatment date(s) stated above may contain mental health, developmental disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency Syndrome (AIDS)/HIV test results and/or other information. The medical records and/or information authorized to be disclosed hereunder are privileged and confidential and may be disclosed only by authorization, except as required by law.

I have the right to revoke this consent at any time as long as such right is exercised in writing. However, I accept that information may have been released before receipt of notice revoking this consent.

A copy of this authorization is as valid as the original.

Signed: _____ Date: _____

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