Golden Rule Family Practice®

Healthcare the way *you* want it.

Patient's Legal Name: _____

Date of Birth: _____

I HEREBY AUTHORIZE GOLDEN RULE FAMILY PRACTICE TO SHARE:

- Any of the following medical information, including information about:
  - Sexually transmitted disease STD testing and treatment *
  - Mental health diagnoses and treatment*
  - Drug and Alcohol use history and treatment *
  - Pregnancy testing and prenatal care*
  - Birth Control/ Family Planning *
- My lab results (note: signing this form does NOT mean we will share result of STD or HIV/AIDS
- My appointment times, dates, and reasons for the visits
- The medication I am taking
- The following information: (Specify) _____

WITH THE FOLLOWING PEOPLE:

Full name: _____ Relationship: _____

Full name: _____ Relationship: _____

Full name: _____ Relationship: _____

Full name: _____ Relationship: _____

I understand that I may cancel this consent at any time (by writing to Golden Rule Family Practice), but that cancelling it will not affect any information that has already been released.

I understand that I do not have to sign this form, and that I should only sign it if I want my medical provider or my clinic to share my information with someone.

Signature: _____ Date: _____

Relationship to minor patient (if parent or legal guardian) * _____

If you are not the minor patient's parent, you must give us proof of guardianship. (Court order/power of attorney)

Witness: _____ Date: _____

A minor patient's signature is required for us to share information and care for: (1) conditions relating to the minor's sexuality including, but not limited to: family planning and sexually transmitted diseases (age 14 and above); (2) alcoholism and/or drug abuse (age 13 and above); and (3) mental health conditions (age 13 and above).