GOLDEN RULE FAMILY PRACTICE

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Portal direct site: https://health.healow.com/goldenrule

PHI CONSENT FORM

Patient's Legal Name: _____

Date of Birth: _____

I HEREBY AUTHORIZE GOLDEN RULE FAMILY PRACTICE TO SHARE:

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

WITH THE FOLLOWING PEOPLE:

Full name:_____Relationship: _____ Phone: _____

Full name:_____Relationship: _____ Phone: _____

Full name:_____Relationship: _____ Phone: _____

Full name:_____Relationship: _____ Phone: _____

I understand that I may cancel this consent at any time (by writing to Golden Rule Family Practice), but that canceling 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: _____

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).