GOLDIN PREMIER MEDICINE

4215 Burns Road, Suite 240 Palm Beach Gardens, FL 33410
Office: (561) 627-6454 Fax: (561) 625-4374

RECORD RELEASE or REQUEST/ AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: ____

First   Middle   Last

Home Address: ______________________________

____

Date of Birth: _______________

SPECIFY INFORMATION TO BE RELEASED OR REQUESTED (CIRCLE WHICH): The information that may be released or requested (circle which) under this Authorization includes:

☐Discharge Summary ☐Progress/Physician Notes ☐X-Ray Report ☐Pathology Report
☐History & Physical ☐Nurses Notes ☐EKG/EMG/EEG Report ☐Consult Report
☐Emergency Report ☐Laboratory Report ☐Operative Report ☐Entire Record
☐Other: ____

Records for the period (dates) from ____________ to ____________

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box.

Information about mental health
Psychotherapy Notes created by a mental health professional
Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
Information about sexually transmitted diseases
Information about alcohol or drug abuse treatment program services
Information about sexual assault
☐Personal history of child abuse and/or neglect

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RELEASE Information To/From ______________________________

Name:

Address:

City: State: Zip Code:

Telephone: Fax:

TERM: This Authorization will remain in effect:

From the date of this Authorization until the _______ day of ______________, 20_____.
Until Goldin Premier Medicine fulfills this request.
Until the following event occurs: ____
Other: ____

RECORD RELEASE / AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I understand that once **Goldin Premier Medicine** discloses my health information to the recipient, **Goldin Premier Medicine** cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that **Goldin Premier Medicine** may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at **Goldin Premier Medicine**; except, however, if my treatment at **Goldin Premier Medicine** is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case **Goldin Premier Medicine** may refuse to treat me if I do not sign this Authorization.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily authorize **Goldin Premier Medicine** to use or disclose my health information in the manner described above.

Patient Signature __________________________________ **Date** ________________________

Signature of Authorized Personal Representative   Relationship to Patient   Date