Patient Authorization to Use or Disclose Protected Health Information
Medical Records Release

I, _________________________________, understand Dr.'s Golden, Began, Aroche, Small & Sweet are authorized by me to use or disclosure my protected health information for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Dr.'s Golden, Began, Aroche, Small & Sweet, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Please check/circle all that applies to the information you would like released:

☐ The patient's entire medical record

☐ Certain Dates of Service: From:__________ To:__________

☐ Medical Data / Specific information related to (specific body part) _________________

☐ Operative Report MRI Results X-ray Reports Lab Work Billing

☐ Other: ____

Please provide the following information:

Name(s), address or fax number of the individual, office or business who are authorized by this form to receive, use and disclose my protected health information.

☐ Self ☐ Other: ____

____

I fully understand and accept the terms of this authorization.

___________________________________ ______________________
Patient's Signature Date

___________________________________ ______________________
Print Name Date of Birth

If not signed by the patient, please indicate the relationship:

☐ Parent or Guardian of Minor patient
☐ Guardian or Conservator of an incompetent patient
☐ Beneficiary or personal representative of a deceased patient

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Account # _______________ ☐ Picked Up ☐ Mailed ☐ Faxed Date:_________________

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