12260 Tamiami Trail East
Unit 102
Naples, Florida 34113
(239) 692-9096

FAX (239) 231-4901

AUTHORIZE:

_____
Name of Provider/Healthcare Facility

_____
StreeAddress

_____
City, State, Zip Code

Phone:_____Fax:_____

RELEASE RECORDS TO:

Goodwin Medical Center
Name of Provider/Healthcare Facility

12260 Tamiami Trail E Unit 102

Naples, FL 34113

Phone**: (239)6929096**

Fax**: (239)231-4901**

Email Address:_____

Print Name_____Birth Date_____SS#_____

I HEREBY REQUEST AND AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:
Please check appropriate areas.

___History and Physical

___Last 2 Progress Notes

___Last EKG/ECHO/Cardiac Notes

__Laboratory Reports Last 2

__ Mammo/PAP/Colonoscopy

__Neuro. Assessments/Tests

I hereby authorize the release of the above information, including psychiatric, alcohol or other drug dependency history or treatment, and HIV/AIDS antibody testing results, to and or from Goodwin Medical Center. I hereby release the above from all legal liability that may arise from the release of information requested. If in the judgement of the medical staff the disclosure of certain information will be harmful if released to the patient, such information may be withheld in accordance with specific state and federal regulations.

This consent will also serve as authorization to disclose information to any person, corporation or agency which is or may be liable for all or part of the physician charges or who may be responsible for determining the necessity, appropriateness, amount or other matter related to the treatment charges, including, but not limited to; insurance companies and/or third-party reviewers. I further authorize disclosure of information to the program's insurance carrier when so requested by the carrier.

I understand that I may invoke this consent to release information in writing at any time, except to the extent that action has been takin in reliance thereon. In any event, upon fulfillment of the above stated purposes, this consent will automatically expire on year from the date signed. I further understand Goodwin Medical Center reserves the right to notify the above-named person, corporation or agency of my revocation if I revoke this consent to release information.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____Date: _____