Family Medical And Wellness Care
Rebecca L. Goldman, M.D.
Mailing Address:
PMB 330
4939 West Ray Road #4
Phone: 480-494-2100 **Fax:** 480-494-2101

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS/PROTECTED HEALTH INFORMATION

Patient's Full Legal Name: _____Patient's Date of Birth: _____

Mailing
Address:_____

City: _____State: _____Zip Code_____

I request and authorize **Family Medical And Wellness Care, PLLC/Rebecca L. Goldman, M.D.** to release medical records/protected health information to:

Provider Name/Facility Name: _____

Mailing
Address:_____

City: _____State: _____Zip Code_____

My signature below indicates that I understand that this authorization may cover Information relating to: (i) AIDS, HIV, and other communicable diseases; (ii) genetic testing; (iii) psychiatric, mental, and behavioral health and treatment; and (iv) alcohol, drug, and substance abuse and treatment. I understand that I may revoke this authorization at any time by providing written notification. I understand that any disclosure made pursuant to this authorization before any revocation shall not constitute a breach of my rights of confidentiality. I understand that this authorization will expire NINETY (90) days following the date of execution. I understand that a photocopy or facsimile of this Authorization is valid in lieu of the original.

Print Name: _____

Signature: _____Date: _____