Paradigm Functional Medicine
Dr. Rachael E Gonzalez, MD

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

WE CANNOT SHARE ANY OF YOUR MEDICAL INFORMATION WITH A SPOUSE/PARENT/CHILD/FRIEND WITHOUT YOUR AUTHORIZATIO**N**

PLEASE FILL OUT THIS FORM IF YOU WANT TO GIVE US THE ABILITY TO COMMUNICATE ABOUT YOUR CARE WITH A SPOUSE/PARENT/ CARE COORDINATOR/FRIEND.

RECIPIENT:

I voluntarily consent to authorize Dr. Rachel West (my health care provider) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

I authorize my health care information to be released to the following recipient(s):

Name: _________________________ Relationship to patient: ____

Name: _________________________ Relationship to patient: ____

Name: _________________________ Relationship to patient: ____

INFORMATION TO BE DISCLOSED:
I authorize the release of the following health information: (check the applicable box below)

- All of my health information that the provider has in his or her possession, including information relating to any medical history, physical condition, and any treatment received by me.

- Only the following records or types of health information:

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Terms:
This Authorization will remain in effect:
- From the date of this Authorization until ______________________

___________________ ___________________ ________________________
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

___________________ ___________________ ________________________
Name of Guardian Date Signature of Witness