Integrated Healthcare of South Florida

Consent to Release Medical, Psychiatric, AIDS/ARC/HIV Testing, Alcohol or Drug Abuse Patient Records

I hereby authorize ____

To RELEASE copies of my Medical Records to Dr. Richard A. Goldman/Andrew Goldstein to:

Integrated Healthcare of South Florida.

I understand that my records may contain information pertaining to my diagnosis or treatment of my medical, psychiatric, AIDS/ARC/HIV testing, alcohol or drug abuse condition. I also understand that any topic discussed during my medical treatment was documented, and therefore, will be RELEASED.
Information to be released: (please circle)

OFFICE NOTES LABS X-RAY AND ALL IMAGING STUDIES EKG ECHO HOLTER
HOSPITAL RECORDS OPERATIVE NOTES HEART CATHETERIZATION ARRHYTHYMIA AND PACEMAKER
ALL

Date of service)s):____

I understand that this release can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. To revoke this consent, written notice must be given. This consent expires in 90 days. Holy Cross Medical Group is released from any legal responsibility of liability; for the release of the above information to the extent indicated and authorized herein.

Signed:____ Date:__________________________

Print Patient Name:____

Patient SS#:______________________________________Date of Birth:_____________________

Patient Address:____
Phone Number:____

Print name of person signing for the patient and their relationship to the patient:
Name:____ Date:___________________

Please send requested information to:

Dr. Richard A. Goldman
Integrated Healthcare of South Florida
9750 NW 33rd Street, Suite 212
Coral Springs, FL 33065

Phone #: 954-546-2688 Fax #: 954-546-2633