Gary Goff MD PA

Internal Medicine

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214-879-9966
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Consent for Release of Information

1. I hereby authorize:
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone: _____
   Fax: _____

   To release the following information from the health record(s) of:
   Patient's Name: _____
   Birthdate: _____Social Security No._____

   Covering the period(s) of treatment: From: _____ To: _____

2. Information to be released:
   □ Progress Notes □ Lab □ Diagnostic Tests □ X-Ray Reports
   □Complete Medical Record

3. Information is to be released to:
   Name: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   Phone: _____
   Fax: _____

4. Purpose of disclosure: _____

5. I understand this consent can be revoked in writing at any time except to the extent that disclosure of information has already occurred prior to receipt of the revocation by Dr. Gary E. Goff, MD, PA. If written revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days.

6. Specification of the date, event, or condition upon which this consent expires:

7. The office, its employees and physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that the information released could contain reference to or results of Psychiatric Evaluation and HIV Antibody (AIDS) testing.

9. A photo static copy of this authorization is to be considered as valid as the original.

   I understand that according to subsection (k), Section 5.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes) a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

   Signature: _____ Date: _____