Dr. Theresa K. Goebel D.O. Kathryn Christenson DNP-C

Dr. Theresa K. Goebel D.O.,P.A.
11786 SE Federal Highway, Hobe Sound, Fl. 33455 Phone: 772-546-4215 Fax: 772-546-8741

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Dr. Theresa K. Goebel D.O.,P.A. "A CORNERSTONE FAMILY PRACTICE"

Address: 11786 SE FEDERAL HWY

City: HOBE SOUND State: FL Zip Code: 33455

This request is for continuity of care unless otherwise listed:_____.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Pursuant to Florida Law and the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. I understand once my information is disclosed to the recipient above, it may be redisclosed to individuals not subject to HIPPA and may no longer be protected by HIPPA. Charges are in compliance with Florida law. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand I may revoke this authorization at any time, in writing, to the address listed above, provided that the information has not yet been released. This authorization expires in six (6) months from date signed unless another date is written here: _____.

Patient or Authorized Signature: _____ Date Signed: _____

Relationship to Patient:_____ Witness:_____ Date:_____