Authorization For Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed
The information covered by this authorization includes:

☐ All medical records	☐ Office notes	☐ Inpatient records
☐ Discharge Summary	☐ Reports of tests and xrays	☐ Outpatient records
☐ Face Sheets with Final Diagnosis	☐ Emergency room records	☐ Abstracts
☐ Procedures and Complications	☐ Consultation reports	☐ Physical therapy
☐ History & Physical Records	☐ Outpatient clinic notes	

☐ Other _____

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:
☐ For my doctor's information ☐ For designated persons information
☐ Other_____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:
MICHAEL W. GOODMAN, M.D.
MATTHEW E. BAGAMERY, M.D.

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

Spouse:_____

Son/Daughter:_____

Friend:_____

Doctor:_____

Other/relationship:_____

Date of Authorization
The effective dates of this authorization: _____ - _____.

Right to Terminate or Revoke Authorization
This authorization may be revoked at any time by submitting a written revocation to MICHAEL W. GOODMAN, MD, P.C., 979 E. Third Street, Suite C-0630, Chattanooga, TN 37403. You should contact the Privacy Officer to terminate this authorization.

_____ _____
date signature o f patient or personal representative

_____ _____
patient's date of birth patient's social security number

_____
printed name of individual's personal representative (if applicable)

_____
rationale for serving as personal representative (i.e. parent, guardian)