Authorization to Release Records

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, chart notes, progress notes, x-rays reports, lab reports, pathology reports, treatment records, examinations, consultations, operative reports, plan of care, initial evaluations, any evaluations, hospitalization, any and all treatment related to my examination. Billing records, reimbursements, employment, wage, payroll, any and all correspondence. Nothing shall be removed, altered withheld or deleted.

Name of Facility: _____

Additional Facilities: _____

_____

_____

Expiration Date: This Authorization is valid for 3 years from the date signed below.

Refusal to sign/right to revoke: I understand that this form is voluntary and that at any time I the patient can revoke this authorization by submitting a written notice of revocation in writing to ***Godfather Docs, LLC.*** The individual has the right to *not* sign this form, by refusing to sign this form it will not affect the ability to obtain and treatment, payments, or eligibility for benefits.

Limitations: This authorization does not grant the authority to copy medical records to any other copy service or business as stated in the Health Insurance Portability and Accountability Act. ***Godfather Docs, LLC*** is a professional business that follows all the **"HIPAA"** rules and regulations and does not disclose any of the information to any third party.

DOB: _____

SSN: _____

Patient name: _____

Signature: _____