



I hereby authorize Good Shepherd Medical Center to release copies of my/ the patient's medical records, including records received from third parties, to the following:

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Dates of my hospital activity were: \_\_\_\_\_ DOB: \_\_\_\_\_

The requested information will be used for: \_\_\_\_\_

I understand that my medical records may include information regarding alcohol or drug abuse, reference to or results of HIV antibody (AIDS) testing, or mental status. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, or to the extent used for the purpose of seeking reimbursement for health care services provided. This consent expires automatically in 180 days.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OR**

Legally Authorized Representative Signature (documentation may be required):

\_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Health Information Management Staff: \_\_\_\_\_ Date: \_\_\_\_\_

**MUST HAVE PHOTO IDENTIFICATION**

Release of Confidential Information Consent Form