GOODMEDICINE
Proactive Solutions for Health and Vitality

Authorization For Release Of Health Information

I,_____ _____

Name of Patient Date of Birth

_____ _____ (_____)

Social Security Number Telephone Number Other Name

Authorize:

Good Medicine
Nathaniel L. Morris, M.D.
5235 Morning Sun Road
Oxford, OH 45056

Release to:

Name: Self/Legal Representative
Address:_____
_____
_____

Please Initial one of the following:

1. I authorize my medical records to be released on an unprotected unencrypted flash drive._____*(Pick up at Good Medicine only)*
2. I authorize my medical records to be released to my secure patient portal on Charm Electronic Health Record._____
3. I have no access to a computer, I authorize my records to be printed._____

This authorization for disclosure of information is effective for one year from date signed. This informed consent is subject to revocation at any time by written notification only.

Patient Signature:_____ Date:_____

OR

Signature of Legal Representative _____ Date:_____

Relationship: _____ Legal Guardian _____ Spouse of Deceased _____ Executor of Estate

_____ Self _____ Power of Attorney for Health Care.