MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Complete the form below and submit to your healthcare provider. This form can be downloaded and printed.

Patient Information

First Name, MI, Last Name

Date of Birth (mm/dd/yyyy)

Phone

Address

City, State, Zip

HealthCare Provider Information

The above patient is (or has been) a patient of the following healthcare facility/provider:

Provider/Facility (Name, Phone number)

Provider/Facility Address (Street, City, State, Zip code)

The above patient authorizes the above healthcare facility/provider to release all medical records and to discuss health information with the following healthcare facility/provider:

Golden Life
ATTN: Danielle Golden
3640 Talmage Circle Suite 216
Vadnais Heights, MN 55110
Tel (952) 431-5330
Fax (952) 431-5334

☐ I understand that release of medical records may include patient histories, office notes, and working diagnoses. It may include drug, alcohol or substance abuse records, mental health records, procedural and surgical records, test results, and current and past medications and treatments. Authorization is valid for 90 days from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily. By submitting this form, I certify that I have completed this questionnaire to the best of my ability.

Patient's Name (please print)

Patient's Signature

Date (mm/dd/yyyy)