I authorize Goodall-Witcher to disclose any and all details of my medical diagnosis, treatment, and billing/claims information to the individuals listed below. This authorization is voluntary and I understand I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my protected health information (PHI) may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

☐ I elect **NOT** to authorize disclosure to any individuals at this time

			Check all that apply below:	
First and Last Name:	Relationship:	Telephone Number:	Medical :	Billing:

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Patient Printed Name:	
Patient DOB:	
Parent/Legal Printed Name:	
Relationship to Patient:	
Signature:	
Date:	