GOLD COAST EQUINE

MEDICAL RECORDS
AUTHORIZATION TO RELEASE / OBTAIN MEDICAL RECORDS

Owner Name: _____

Patient Name: _____Species: _____ Case #_____

Address: _____ City: _____ State: _____ZIP: _____

I authorize Gold Coast Equine to release the above named patient medical records to:

Name:	
Address:	
City/State/Zip Code:	
(Area Code) Phone:	(Area Code) Fax:
Email Address:	

Description of information that may be disclosed:

- ☐ Dates of service From: _____ Through: _____
- ☐ Laboratory Results
- ☐ Imaging Reports (Radiographs, US, CT, MRI, NM)
- ☐ Imaging Studies via email (Radiographs, US, etc.)
- ☐ Entire Medical Record

The information will be used/disclosed for the following purposes:

- ☐ Continuity/Transfer of Care
- ☐ Legal
- ☐ Insurance/Payment of Bills
- ☐ Other: _____

I understand that by authorizing Gold Coast Equine, to use/disclose the information, that they may receive compensation for reasonable expenses incurred for making photo copies of medical records.

I understand that I may revoke this authorization in writing at any time by contacting Gold Coast Equine, except to the extent that action has been taken in reliance on this authorization.
This authorization expires _____ (insert applicable date or event), on or within (6) months or the date of the authorization, whichever is greater.

Owner Signature:_____ Date:_____

Please return signed and completed form to Gold Coast Equine's email at staff@goldcoastequine.com or mail to Gold Coast Equine, 3882 Llano Rd Santa Rosa, CA 95407.