AUTHORIZATION TO RELEASE PATIENT INFORMATION

I authorize Michael P. Golden, M.D., P.A., and/or its member physicians, Michael P. Golden, to release and furnish on a confidential and a strict need to know basis all medical and financial data related to my care that may be necessary now or in the future to facilitate payment by third parties for services rendered by Physician, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary physician or any other physician that is directly or indirectly responsible for my medical care or the payment thereof.

Date:_____

Patient Name:_____

Patient or Legal Guardian Signature:_____