



Kenneth E Goolsby MD
& Associates PC

Psychiatry and Transcranial Magnetic Stimulation

Kenneth E. Goolsby, M.D.
Rob Findley, P.A./C.

Cassie Farr - Practice Administrator
Gail Corpus - TMS Coordinator

Patient's Full Name

Medical Record Number

Address

Patient's Date of Birth

City, State Zip Code

Patient's Telephone Number

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

2. The following person (or class of persons) may receive disclosure of protected health information about me:

His/her/its Name

Address

City, State Zip Code

3. The specific information that should be disclosed is (please give dates of service if possible):

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying Kenneth E. Goolsby, MD & Associates, PC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____.
7. This authorization expires on _____, 2020 OR upon notification to withdraw or revoke this request with the office in writing.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual*

(The person about whom the information relates)

OR, if applicable –

Date of Individual's Signature

**Date of Birth or
Social Security Number**

**Signature of Guardian* or
Personal Representative of Patient's Estate**

**Date of Guardian's/Personal
Representative's Signature**

**Description of Authority to Act
for the Individual**