I, _____, hereby authorize Dana M. Goldberg M.D.
(Patient Name/Legal Guardian)
to receive all copies of my medical records and/or x-rays protected health information.

Dana M Goldberg MD
224 Chimney Corner Lane
Suite 1002
Jupiter, FL 33458
(561) 691-8088 Phone
(561) 328-9683 Fax

This authorization is given pursuant to Florida Statue 456.057 and HIPPA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patient's legal representatives.

Description of information to be disclosed:
_____
_____
_____
_____

_____ _____
Print First & Last Name of Patient Patient's Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Name of Guardian or Legal Representative Signature State Relation of Patient