



**Coastal Medical**

*Lifespan. Delivering health with care.®*

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_

Email Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Records to be released to:** (Please complete in Full)

**Records to be released from:** (Please complete in Full)

**To:** \_\_\_\_\_

**From:** \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Delivery Method:** Paper \_\_\_\_\_ Electronic: \_\_\_\_\_ (For Patient request)

\* **Specific Dates of Service(s) Requesting** \_\_\_\_\_ To \_\_\_\_\_

Progress/Consult notes

Laboratory Reports

X-Ray Reports

Abstract Records (Progress notes/Tele visits, Lab reports, Xray reports, Special Studies)

For continuation of care, we provide last 2 years

Complete Record (Last 10 years)

**Reason for Request:** \_\_\_\_\_

This authorization includes permission to transfer information regarding AIDS, HIV, Psychiatric disorders, and history of treatment for drug and alcohol abuse.

Have you seen a behavioral health specialist in our office?:  Yes If yes, by whom?: \_\_\_\_\_  No

Do you authorize the release of these records as well?:  Yes  No

I understand that behavioral health diagnoses and medication are included in my medical records and will be included in this release of Medical Records Information.

I understand that I may revoke this authorization at any time prior to an actual release of records made in good faith that occurred in reliance on this authorization.

This Authorization will automatically expire in 120 days from the date signed below.

**This Authorization does NOT allow an agency receiving records from further distributing them without additional written consent of the patient.**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by Legal guardian or representative, please include the legal documents providing your authority.

\* Requests for patient's medical records will be billed to the patient according to state regulations