Coastal Medical
Lifespan. Delivering health with care.®

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ Address: _____

Date of Birth: _____/_____/_____ _____

Telephone: _____ _____

Transfer the following information:

To:* _____ From: _____

_____ _____

_____ _____

- ☐ Abstract of last 2 years for continuation of care**
- ☐ Complete record
- ☐ Other _____
- ☐ Consultation notes
- ☐ Laboratory Studies
- ☐ X-ray reports

This authorization includes allowing the transfer of information regarding: AIDS (Acquired Immunodeficiency Syndrome), HIV (Human Immunodeficiency Virus), psychiatric disorders, and history of treatment for drug or alcohol abuse.

Have you seen a behavioral health specialist in our office? ☐Yes ☐No

If yes, what is the provider's name? _____

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 record and will be included in releases of medical record information.

I understand that this authorization may be revoked 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 90 days from the date below.

The purpose of this request is: _____

Signed: _____ Date: _____
Patient/Legal Guardian

Witness: _____

THIS AUTHORIZATION DOES NOT ALLOW AN AGENCY RECEIVING RECORDS FROM FURTHER DISTRIBUTING THEM WITHOUT ADDITIONAL WRITTEN CONSENT OF THE PATIENT.

* Requests for the patient's records will be billed to the patient according to state regulations. You may have a personal copy delivered to you electronically upon request.

**Abstract includes progress notes, laboratory and other testing results, telephone encounters, and consultation documents from the last two years; additional preventive immunizations and most recent mammogram, colonoscopy and cardiac testing results will be forwarded if present.