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)

To: _____ **From:** Coastal Medical **(Please indicate proper selection below)**

Address: _____ *All Coastal Medical Practices*/Providers ☐

City: _____ State: _____ Zip Code: _____ **Specific Coastal Practice/Provider*: _____*

*Note: If you indicate a specific Coastal Practice/Provider, you will only receive records from that provider and/or practice. If you were seen by one of our specialists or at C365, these notes would **NOT** be included.

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