Coastal Medical
ASSOCIATES

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME:___________________________________DOB:____________________

I HEREBY AUTHORIZE COASTAL MEDICAL ASSOCIATES, TO RELEASE AND/OR DISCLOSE BY PROTECTED HEALTH INFORMATION TO:

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FOR THE PURPOSES OF:

________**Transfer of care to new PCP**
________**Consultation to specialist**
________**Other: (please specify**)
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The information authorized for disclosure may relate to: (check all that apply)

__Complete Medical Record; __Mental illness;__ HIV/AIDS test/treatment;_ _Drug/Alcohol Treatment.

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING COASTAL MEDICAL ASSOCIATES, HOWEVER, SUCH REVOCATION DOES NOT AFFECT ANY ACTIONS TAKEN ON THIS AUTHORIZATION BEFORE RECEIPT OF SAID REVOCATION. I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE SIGNED.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION COULD BE SUBJECT TO REDISCLOSE BY A RECIPIENT AND, IF SO, MAY NOT BE SUBJECT TO FEDERAL OR STATE LAW PROTECTING ITS CONFIDENTIALITY.

I UNDERSTAND THAT I MAY INSPECT OR COPY THE PROTECTED HEALTH INFORMATION DESCRIBED BY THIS AUTHORIZATION.

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DATE **SIGNATURE OF INDIVIDUAL OR REPRESENTATIVE**