AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION FROM OTHER HEALTHCARE FACILITIES

Name:_____ SS#:_____

Telephone #: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____

State: _____ Zip: _____

Name of Health Care Facility from which Records are Requested:

_____

Address: _____ City: _____

State: _____ Zip: _____

Dates of Treatment Requested: _____

Information Requested: _____

Reason for Disclosure: _____

MAIL OR FAX INFORMATION TO: Coastal Medical Clinic PC
1500 Hwy 17 N Business
The Courtyard, Suite 307
Surfside Beach, SC 29575
Phone: 843-477-1602
Fax: 843-477-1603

I hereby authorize Coastal Medical Clinic PC to obtain the health information that is contained in my patient records to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses. This authorization does not include permission to release outpatient Psychotherapy Notes. The release of Psychotherapy Notes requires a separate authorization. Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical record.

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire one year from the date of authorization written below.

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ _____

Signature of Patient *Printed Name*

Date Signed: _____/_____/_____