COASTAL SURGEONS

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

NOTE: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions. Or alcohol/substance abuse have special rules that require specific authorization.*

AUTHORIZATION

I hereby authorize: Physician / Healthcare Facility: _____
Address: _____
Phone: _____
Fax: _____

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above-named health care provider may hold, by means of mail, fax or other electronic methods.

Release information to:

Physician / Healthcare Facility: _____
Address: _____
Phone: _____
Fax: _____

This medical information/records will be used for the following purpose: _____

This authorization is:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

☐ Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse *(Initial)* _____
Psychiatric/Mental Health *(Initial)* _____
Test for Antibodies to HIV *(Initial)* _____
HIV Diagnosis/Treatment *(Initial)* _____
Genetic Information *(Initial)* _____

DURATION: This authorization shall be effective immediately and remain in effect until: _____/_____/_____.

RESTRICTIONS:

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

Signature of patient *OR Legal/Personal Representative* _____ Relationship *if other than patient* _____

Patient's Name (Please print) _____ Date _____

Patient 's Social Security Number _____ Patient's Date of Birth _____

Witness Name _____ Witness Signature _____