# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____________________________________________________________

Date of Birth: ____________________________

I understand that this authorization will allow the below provider and/or facility to obtain, use, and/or disclose my protected health information. I understand that my medical records may contain sensitive information such as mental health, AIDS, HIV, substance abuse, and/or other related conditions. I understand that these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without written consent. In addition, I understand that these records will not be released to entities other than those designated by myself or my personal representative as provided by state or federal law.

I hereby, give my permission to the providers and/or facilities on the reverse side of this page (or Page 2 if printed at home) to release my detailed medical records to:

**Coastal Family Practice and Internal Medicine, LLC**
1004 South Old Dixie Hwy, Suite #201, Jupiter, FL 33458
(Ph) 561-284-8383 (Fax) 561-284-8380

I understand the following:

The information released will be to provide continuity of care and could include sensitive information; the provider and/or facility will release only the pertinent information necessary to fulfill the request;
Authorizing the disclosure of this information is voluntary;
This authorization is valid for one (1) year from the date of signature unless I send a written request to revoke this request.

Patient Signature: ________________________________________Date: _________________________

**<u>Or</u>**

Legal Guardian/Authorized Person Name: __________________________________________________

Guardian/Authorized Person Signature: ______________________________________________________

Date: _________________________________

Relationship to Patient: __________________

# Coastal Family Practice and Internal Medicine, LLC

1004 South Old Dixie Hwy, Suite #201, Jupiter, FL 33458
(Ph) 561-284-8383 (Fax) 561-284-8380

Please send **MOST RECENT** lab and test results, imaging results, EKGs, and medical notes

**Patient Name:** ______________________________ **Date of Birth:** ________________

Doctor's Name: ______________________________
Address: ______________________________________________________________
Phone: ____________________________ Fax: ______________________________

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Address: ______________________________________________________________
Phone: ____________________________ Fax: ______________________________

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