



Authorization to Release Information

825 Diligence Drive Suite 206 Newport News, Va 23606
Phone: 757-310-6900 Fax: 757-240-5936

Patient Name: _____ Date of Birth: _____

Address: _____

SSN: _____ Contact Phone Number: _____

I, _____ do hereby authorize *Coastal Medical and Psychiatric Services* to:

Obtain Information and/or Disclose Information

From: _____
Name of Company/Person/Agency/Self

Address: _____

Phone/Fax: _____

Purpose of Disclosure:

- | | | |
|--|--|---|
| <input type="checkbox"/> Change of Physician | <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Disability Determination |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Referral to Specialist | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Legal Investigation | <input type="checkbox"/> Obtain Personal Records | <input type="checkbox"/> Other _____ |

Please indicate below the information you would like disclosed

- | | | |
|--|---|--|
| <input type="checkbox"/> Complete Medical Record | <input type="checkbox"/> Initial Assessment | <input type="checkbox"/> Test/Lab Results |
| <input type="checkbox"/> Medication History | <input type="checkbox"/> Progress notes | <input type="checkbox"/> Psychological Testing or Consults |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Drug abuse or dependency treatment | |
| Other: _____ | | |

Which method would you like to use to release your medical documents?

- Fax Telephone Standard Mail Verbal

I understand that after the custodian of records discloses my health information, it may no longer be protected by Federal Privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that such a revocation will not apply to information that has already been released in response to this authorization.

Signature: _____

Date: _____

Office Witness: _____

Date: _____