Phone (757)310-6900 Secure Fax (757)240-5936

Authorization to Release Information to PRIMARY CARE PHYSICIAN

*Patient Name: ____________________________ *Date of Birth: _____/_____/_____

______ - **Please initial if you do not have a PCP or do not want to disclose information to them**

I hereby authorize Coastal Medical and Psychiatric Services to obtain and disclose information regarding my care from:

*Name of Agency/Provider: ____

*Phone/Fax: ______________________________________

Dear _______________,

Your patient was seen by me on _______________________________________. His/her plan of care includes:

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If you have any questions, please do not hesitate to contact our office.

Sincerely,

*Print Patient Name and/or Legal Guardian: ________________________ Date: ________________

*Signature:____

This release may remain valid until revoked in writing or until termination of care with either provider.