Coastal Internal Medicine & Geriatrics

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Authorization for Release of Medical Records

I, _____, hereby authorize **Coastal Internal Medicine & Geriatrics** to receive my medical information from (Primary Care Doctor / Family Doctor / Specialist / Other) _____.

Information to be received:

- ☐ Entire Medical Record of last two (2) years
- ☐ Entire Medical Record
- ☐ Office Visit
- ☐ Laboratory Reports
- ☐ Discharge Summary
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Emergency / Urgent Care Record
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Other _____

I understand that any information, including drug use, alcohol abuse, psychiatric condition and/or communicable diseases will be released as part of my records. I understand that I may, at any time, revoke this authorization, but revocation will not apply to any records that have already been released. I understand that a COPY or FAX of this document is valid as an original document.

Purpose: Continuity of Care

Signature: _____ Date: _____

Patient DOB: _____

- You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on 1/4/17" or, if your entire medical record is included, "all health information.").*
- You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*
- You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*
- You have the right to alter this request. We have preprinted options for your convenience. You may alter these items if needed.
- You have the right to receive a copy of this form