



Coastal Internal Medicine & Geriatrics

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Authorization for Release of Medical Records

I, _____, hereby authorize **Coastal Internal Medicine & Geriatrics** to release/receive my medical information to/from _____.

Information to be released or received :

- | | |
|--|---|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Office Visit | <input type="checkbox"/> Emergency / Urgent Care Record |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> 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 and that this authorization will expire in 90 days from signature date.

Purpose: Continuity of Care

Signature: _____ Date: _____

Patient SSN: _____

Patient DOB: _____

Provider: _____

Phone: _____ Fax: _____

- 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