RELEASE OF INFORMATION

Phone: 757-223-7098 or 757-310-6900 Fax: 757-240-5936

Patient Name: _____ Date of Birth: _____

SSN:_____ Contact Phone Number: _____

I authorize the custodian of records of: **Coastal Medical and Psychiatric Services Inc.**

This release is to: [ ] Be kept on file

1. Name: _____ Medical / Billing

Relationship: _____ Phone Number: _____

2. Name: _____ Medical / Billing

Relationship: _____ Phone Number: _____

3. Name: _____ Medical / Billing

Relationship: _____ Phone Number: _____

4. Name: _____ Medical / Billing

Relationship: _____ Phone Number: _____

Please Indicate below the information you would like disclosed

_____ Care and condition
_____ Test Results
_____ Psychological/Mental Health/Psychiatric Information
_____ Pick Up Prescriptions
_____ Pick Up Samples
_____ Pick Up Forms
_____Make/Cancel Appointments

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 by my request to release my medical records to the entity or facility listed above. 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 by signing this release form, if I have requested a copy of my medical records previously, that there may be a charge for an additional copy.

Signature: _____ Date: _____