Authorization to Release Information

825 Diligence Drive, Suite 100 and 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 & Psychiatric Services** to:

[ ] Obtain Information From and/or **[ ] Disclose Information To**

Name of Company/Person/Agent: ____

Address: ____

Phone: ______________________________ Fax: _______________________________

Purpose of Disclosure:

__ Change of Physician
__ Personal
__ Legal Investigation
__ Continuing Care
__ Referral to Specialist
__ Obtain Personal Records
__ Disability Determination
__ Insurance
__ Other_______________

Please indicate below the information you would like disclosed:

__ Complete Medical Record
__ Medication History
__ Insurance
__ Initial Assessment
__ Progress Notes
__ Test/Lab Results
__ Drug abuse/dependence treatment
__ Psychological Testing/Consults
__ 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: ____________