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:

_____

_____

_____

_____

_____

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

Sincerely,

***Signature of Patient or Legal Guardian: _____ Date: _____**

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