COASTAL PRIMARY CARE

INTERNAL MEDICINE / FAMILY PRACTICE

2215 Nebraska Avenue, Suite 3A
Fort Pierce, Florida 34950
(772) 489-6011

Midway
4995 South US Highway One
Fort Pierce, Florida 34982
(772) 465-3225

145 NW Central Park Plaza, Suite 103
Port St. Lucie, Florida 34986
(772) 480-0011

TO: _____

_____

_____

AUTHORIZATION OF RELEASE OF MEDICAL RECORDS

RE: Name of Patient_____

Social Security #_____

I authorize the release of my medical records, specifically to include the following:

Complete Medical Records_____ Lab Reports_____ Consultations_____

Medication_____ Other_____

This medical record may contain information about drug abuse, substance abuse, mental health treatment and HIV/aids information. Separate consent must be given to release this information.

_____ **I DO** consent to having this information disclosed

_____ **I DO NOT** consent to having this information disclosed

The purpose of this request is for diagnosis and treatment.

These records are to be sent to the above address.

This authorization will expire 90 days from the date of signing.

I have the right to revoke this authorization at any time, in writing, except to the extent of information that has already been released.

I have reviewed this authorization. I understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.

DATE: _____/_____/_____

_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative