Authorization to Disclose Health Information

I, the undersigned, authorize

FL295: COASTAL NEUROLOGY ASSOCIATES
421 Kingsley Avenue, #401 Orange Park, FL 32073

Patient Information:

Patient Full Name: _____ Email address: _____

Patient Address: _____ Date of Birth: _____

City: _____ State _____ Zip: _____ Phone #: _____

Release Information To:

-This box must be complete in order for request to be processed-

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Disability
☐ Transfer/Reason_____ ☐ Other_____

Information to be Released:

Unless otherwise specified, only the following information will be released:
Medical History, Progess Notes, Lab Reports , Diagnostic Testing, and Surgical Reports.

☐ **Please provide a 2 year Abstract of my records**

☐ **Other (Please be specific)**

Comments: _____

_____

Authorization to Release Protected:

***Required** - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one		*Initial each line below*
I ☐ DO	☐ **DO NOT** want information about ***Mental Health** released	_____
I ☐ DO	☐ **DO NOT** want information about ***HIV Tests** & **Related Information** released	_____
I ☐ DO	☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ DO	☐ **DO NOT** want information about _____ released	_____

"Other sensitive information?"

STOP Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Patient's Signature:_____Date:_____
(Required for all patients 18 years and older. 18 years and older for psychiatric records, 14 years and older for substance use records)

Signature of Parent or Legal Guardian:_____Date:_____
(Required for all patients under the age of 18 unless otherwise allowed by law. If not the parent, legal representation documentation must be supplied)

- *This authorization will expire 90 days from the date appearing above. I understand that I may revoke this authorization at any time by notifying Coastal Neurology Associates in writing, but if I do, it will not have any effect on the actions the hospital took before it received the revocation.*
- *I understand that under the applicable law the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and no longer subject to the protections of the privacy standard.*
- *I understand that my treatment or continued treatment by Coastal Psychiatry and its affiliates is no way conditioned on whether or not I sign the authorization and that I may refuse to sign it.*
- *I understand that I may inspect or copy the information that is used or disclosed*