COASTAL PEDIATRICS

Authorization for release of Protected Health Information (PHI)

Phone 843-347-4677 Fax: 843 347 4678

Please complete the following section (print clearly)

Patient Name:_____ Date of Birth:_____

Street Address:_____

Phone:_____

City:_____: State:_____

Zip:_____

Physician/Hospital Authorized to release information:_____

Requested Date(s): From:_____ To:_____

Release Information : _____.

_____.

Specific Description of Phi Use/Disclosure:

{} Progress Notes {} Consultation Reports {} Lab Reports {} History/Physical
{} Discharge Summary {} Immunizations {} All Medical Records {} Other

I understand that I may refuse to sign the authorization and that it is strictly voluntary. I may revoke this authorization at any time in writing, but it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice Of Privacy Practices. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations and may be redisclosed. I understand that I may see and obtain a copy of the information described on the form, for a reasonable copy fee, if I ask for it. If requested, I

may receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the Protected Health Information as stated.

Patient/Guardian:_____.
Relationship to Patient:_____. Date:_____.

This authorization will expire in 12 months unless otherwise specified.