AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Complete One Form Per Patient and for use in Florida only

Coast Ultrasound
Affordable Excellence in Diagnostic Ultrasound Services

PATIENT INFORMATION:

Name _____ Date of Birth _____

Street Address City, State, Zip Code _____ Social Security _____

Email Address _____ Phone Number _____

RELEASE MEDICAL RECORDS FROM:

Name _____

Phone Number _____

Street Address _____

Email Address / Fax Number _____

RELEASE MEDICAL RECORD TO:

Name _____

Phone Number _____

Street Address _____

Email Address / Fax Number _____

DATES OF SERVICE: (REQUIRED) ____/____/____ to ____/____/____

MEDICAL RECORDS TO BE RELEASED: (REQUIRED)

__Radiology Reports ___Imaging ___Other _____

PURPOSE OF RELEASE: (REQUIRED)

____ Referring Physician

____Personal ____Referral to Specialist ____Disability Determination _____Insurance _____Legal Investigation

___Other (please specify) _____

SIGNATURE OF LEGAL REPRESENTATIVE OR PATIENT (IF PATIENT IS 18 YEARS OR OLDER):

I acknowledge I am a legal representative, or an authorized person of the patient listed above. By signing below, I am authorizing the release and disclosure of the patient's protected health information. This authorization is valid 12 months from the date of signature. I understand that I may cancel this request with written notification, and it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether I sign the authorization.

Signature of Legal Representative/Patient 18yrs or older _____ Date _____

Printed Name of Legal Representative/Patient 18 yrs or older _____ Relationship to Patient _____