

COASTAL EAR, NOSE & THROAT

A FLORIDA ENT ASSOCIATES PRACTICE



Authorization For Release of Protected Health Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Social Security: _____ Home Phone: _____

I hereby request and authorize the following:

Coastal Ear, Nose & Throat
3 Pine Cone Drive, Suite 105,
Palm Coast, FL 32137

P: (386)760-6601
F: (386) 222-0769

To release to:

_____ A complete copy of all of the above named patient's medical records, including all records to mental health, drug, or alcohol conditions, or HIV status, if applicable.

_____ A copy of the above named patient's medical records, limited to the following: _____

_____ Actual X-ray films or copies: We understand that these films are a part of your permanent record and are released on a loan basis only. We will return the films after our review of them.

The purpose of this disclosure and release is _____.

I hereby release _____ and its employees, agent, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this consent for release of medical information.

This authorization and request shall be valid until the disclosure is complete or up to 90 days after the date below, after which time it shall expire. This authorization may be revoked by submitting a written revocation to Coastal Ear, Nose & Throat at any time.

PATIENT SIGNATURE

DATE

PATIENT REPRESENTATIVE OR GUARDIAN SIGNATURE (IF PATIENT IS LESS THAN 18)

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT

WITNESS SIGNATURE

_____ Patient has been advised regarding the costs for copying medical records.

Requestor's Signature: _____