



PH: (904) 332-6774 FAX: (904) 661-0028

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Parent/Guardian Name: _____ Relationship: _____

Patient's Address: _____

Phone Number: _____

Copies of patient's records to be released **from** Coastal Cosmetic Center, 4147 Southpoint Dr. E., Jacksonville, FL 32216.

Released to: _____

(Check selection): Self Spouse Domestic Partner Child (Adult) Parents/Guardian
 Other: _____

For the specific purpose(s) I have checked below:

- Continuing medical treatment
- Labs/Pathology/Diagnostics
- FMLA/Short-term
- Photos
- Second opinion
- Disability Forms
- Residence relocation
- Patient Request
- Other: _____
- All lab reports

As part of the Medical Records, the following information will be released unless stricken and initialed by the patient:

- HIV/AIDS related information and/or records
- Mental Health information and/or records
- Other: _____
- Drug/alcohol diagnosis, treatment, or referral information
- Sexually transmitted diseases

Time period for disclosure:

- This is a one-time disclosure
- This is a continuous disclosure for 12 months beginning _____

Right to Revoke Authorization: I, the patient, may revoke this authorization at any time in writing.

Copying Charges:

a) For patients and government entities: \$1.00 per page for the first 25 pages and \$0.25 for each page in excess of 25 pages.

b) For all other entities: \$1.00 per page. This is in accordance with Florida Administrative Code 64B8-10.003.

****Please allow 2 weeks for the reproduction of the requested records****



Authorization and Signature:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Coastal Cosmetic Center, P.A., from all liability from this disclosure of my health information.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Name (Print) : _____ Date : _____

Patient Signature : _____

Parent/Guardian/Legal Representative (Print): _____

Parent/Guardian/Legal Representative (Signature): _____

Send by:

Fax (to provider's offices only)

Name of recipient AND fax number: _____
Patient's Initials _____

Certified Mail at patient's expense

Name of recipient AND address: _____

Patient to pick up

Records needed by: ____/____/____ **(Please allow 2 weeks for the reproduction of the requested records)**

OFFICE USE ONLY:

Doctor signature: _____ Date: _____

Office Administrator signature: _____ Date: _____

Risk Manager signature: _____ Date: _____