Coastal Carolina Health Care, PA

Authorization for Disclosure of Protected Health Information

Name of Patient:_____ MR #:_____

Date of Birth:_____ SS #:_____
(Providing your SS# is voluntary, but necessary to accurately identify your medical records. Failure to provide this information may delay processing your request.)

Patient Address:_____
Street State Zip

Phone #:_____

I authorize the disclosure of protected health information about me as described below.

1. I authorize the provider(s) listed below to disclose protected health information about me for the purpose of communicating information regarding my treatment and diagnosis, that includes test results, and to discuss my account balances and insurance information:

COASTAL CAROLINA HEALTH CARE, P.A.

2. I authorize the above listed providers to disclose protected health information about me to the persons listed below for the purpose of communicating information to them regarding my treatment and diagnosis, including test results, and to discuss my account balances and insurance information:

_____
_____
_____

3. I understand that if persons I have listed above are not health care providers covered by federal privacy regulations that the information described above may be re-disclosed and no longer protected by these regulations.

4. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any written information disclosed under this authorization.

5. I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on this authorization.

6. This authorization expires in: (Please Circle)

1 week 1 month 6 months 1 year 5 years

_____
Signature of Patient

_____
Patient's Name Date