Coastal Urology, PLLC

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name:_____Date of Birth:_____

I,_____hereby authorize the Release of Medical Records, including but not limited to, office notes, lab results, and diagnostic tests for myself/dependant to Coastal Urology, PLLC.

Must be completed for all authorizations

I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying the office in writing and that this will automatically expire on _____/_____/_____ (DD/MM/YR) or 180 days from the date signed below, which ever is earlier.

This hereby releases the sender for all legal responsibility or liability of the release of information described above from the records. I also understand that if I revoke my authorization, it will not have any effect on any actions Coastal Urology, PLLC took before it received the revocation.

I understand that medical records, laboratory reports and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

Name:_____Date:_____/_____/_____

Signature:_____Date:_____/_____/_____
Signature of Patient/Guardian