PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient_______________________________________Medical Record #_________

Date of Birth________________________Social Security #___________________________
(Providing your SS# is voluntary, but not necessary to accurately identify your medical records. Failure to provide this information may delay processing your records.)

Patient Address____
Street Address State Zip code

Phone #____

Approximate Dates of Treatment____
From To

1. I authorize the following health care provider or facility to **<u>DISCLOSE</u>** my patient information:
   Name of Health Care Provider or Facility:___________________________________
   Phone #_____________________________Fax #________________________________
   Address:____
   Street Address State Zip code

2. I authorize the following health care provider or facility to **<u>RECEIVE</u>** my patient information:
   Name of Health Care Provider or Facility:______________________________
   Phone #________________________________Fax #______________________________
   Address:____

3. Please disclose the following information: (Circle to indicate your selection)
   History and Physical — Discharge Summary
   Treatment Plans — Office Notes/Nursing Notes
   Radiology and Lab Reports — Consultation Reports

4. I understand that this authorization included consent for the release of alcohol, drug, psychiatric, and psychological information; and any information relating to pregnancy, sexually transmitted disease, HIV testing, AIDS and any AIDS related syndromes. It also includes any information concerning cancer, cancer testing, and cancer results.

5. Please indicate the purpose of the disclosure of your patient records:

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6. I understand that if the authorized recipient of this information is not a health care provider or health plan covered by Federal privacy regulations and the recipient may re--disclose the information. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

7. I understand that Coastal Carolina Health Care, P.A. will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may inspect or copy any information used or disclosed under this authorization.

8. I understand that personally requesting a copy of my patient records (request not made by a physician or other health care provider for treatment purposes) will result in a record copying fee. By signing this document I agree to pay $6.50 for record copying fees:

9. This authorization expires: (Circle one)

1 year from the date I sign below 90 days from the date I sign below

I understand that I may revoke this authorization, except to the extent that action has already been taken, in writing at any time by sending written revocation of authorization to the releasing provider. If I have further questions, I may contact CCHC Privacy Officer. Phone (252) 514-6685, e-mail: privacy@cchealthcare.com.

I hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are a part of my medical records. I agree that a copy of this release of a fax of this release shall be valid as the original release.

____ ____________________

Signature of Patient or Representative Date

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Patient’s Name

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Name of Personal Representative

If signing as a Personal Representative, describe authority to act for patient and submit documentation showing such authority:

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Signature of Witness who verified identification of patient or personal representative