Coastal Nephrology & Hypertension Center, P.A.
Coastal Internal Medicine of Jupiter, P.A.

641 University Blvd. Ste. 211 Jupiter, FL 33458
Phone: (561) 253-8121 Fax (561) 253-8021

Authorization for Release of Medical Records

Patient Name (Print): Social Security #: Patient DOB:

_____ I authorize Coastal Nephrology & Hypertension Center, P.A.to use or release/disclose my health information as described below.

Please identify the information to be released:

- ☐ Please release my entire record
  -OR-
- ☐ Please release ***only*** the following information (check appropriate boxes and include other information where indicated):
  - ☐ Problem list
  - ☐ Medication list
  - ☐ List of allergies
  - ☐ Immunization records
  - ☐ Most recent history
  - ☐ Most recent discharge summary
  - ☐ Lab results (dates):_____
  - ☐ X-ray and imaging reports (dates):_____
  - ☐ Other (please describe): _____

The identified information will be used for the following purpose:

- ☐ My personal records
- ☐ Sharing with other health care providers as needed
- ☐ Other (please describe): _____

Please initial each item below to indicate your understanding.

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

The identified information may be used by or released to the following individual(s) or organization(s):

Name:_____ Phone: _____

Address:_____ Fax: _____

_____

Signature of patient, parent, guardian, or personal representative Date

_____

Witness Signature Date

*This authorization will expire twelve (12) months from the date on which it was signed.