Coastal Eye Care, PA
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Authorization to Release Healthcare Information

Name: _____ Date Of Birth: _____

Address: _____ Account #: _____

_____ Telephone: _____

I, _____ hereby authorize Coastal Eye Care, PA, its authorized employees or agents, to disclose and discuss records containing the following information to _____ for the following dates of service _____.

I, _____hereby authorize _____, and authorized employees or agents, to disclose and discuss records containing the following information to Coastal Eye Care, PA for the following dates of service_____.

Inpatient _____ Outpatient _____
Emergency Room _____ Test Results_____
Specific Illness/Injury _____ Clinic_____
Other information to be disclosed (specify): _____

The purpose of this release is: _____ .

I understand that my medical records contain information relating to my diagnosis and treatment and authorize the release of all such information listed above, except those items I have crossed out or specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or other insurance, or other adverse consequences. Partial or incomplete records will be labeled as such.

This Authorization expires 12 months from this date. However, I understand that I can revoke this authorization at any time prior to the above date by notifying Coastal Eye Care, PA of the revocation. Such revocation must be in writing, signed and dated and shall be effective when received, subject to the rights of any person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis of denial of health benefits or other insurance coverage or benefits.

Coastal Eye Care, PA is not responsible for any re-release or misuse of the above requested information by the receiving party.

I (Do/Do Not) authorize release of HIV infection status information contained in the record.
Such information may not be re-disclosed by the recipient without my specific written consent.

I (Do/Do Not) authorize release of Alcohol or Drug abuse or Psychiatric information contained in the record. Such information may not be re-disclosed by the recipient without my specific written consent.

I understand that I am entitled to a copy of this authorization form.

_____ _____
Date Signature/Authorized Representative

_____ _____
Date Signature/Witness