Coastal Medical
ASSOCIATES

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENTS NAME:____DOB_________________

I HEREBY AUTHORIZE____TO USE AND/OR DISCLOSE MY PROTECTED HEALTH INFORMATION TO:

COASTAL MEDICAL ASSOCIATES
ONE WALLACE BASHAW JR. WAY
SUITE 2003
NEWBURYPORT, MA 01950

FOR THE PURPOSE(S) OF: **( ) TRANSFER OF CARE**
( ) SPECIALTY APPOINTMENT
( ) PERSONAL RECORDS
( ) SPECIFIC RECORDS ONLY:________________________________

THE INFORMATION AUTHORIZED FOR DISCLOSURE MAY RELATE TO: (CHECK ALL THAT APPLY)

____MENTAL ILLNESS _____HIV/AID TESTS AND/OR TREATMENT ____ DRUG/ALCOHOL TREATMENT

I UNDERSTAND THAT I MAY INSPECT OR COPY THE PROTECTED HEALTH INFORMATION DESCRIBED BY THIS AUTHORIZATION. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING COASTAL MEDICAL ASSOCIATE'S, HOWEVER, SUCH REVOCATION DOES NOT AFFECT ANY ACTIONS TAKEN ON THIS AUTHORIZATION BEFORE RECEIPT OF SAID REVOCATION. I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE SIX MONTHS FROM THE DATE SIGNED. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION COULD BE SUBJECT TO REDISCLOSURE BY A RECEPIENT AND, IF SO, MAY NOT BE SUBJECT TO FEDERAL OR STATE LAW PROTECTING ITS CONFIDENTIALITY. I UNDERSTAND THAT COASTAL MEDICAL ASSOCIATE'S SHALL NOT CONDITION MY TREATMENT ON MY PROVIDING AUTHORIZATION FOR THE REQUESTED USE OF DISCLOSURE AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

____ ____
Date Signature of Individual or representative