Coastal Cardiology, P.A.

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1033 St. Andrews Blvd • Charleston, SC 29407 • (843) 723-6111
Satellite Offices | Mt. Pleasant • Moncks Corner • Carnes Crossroads

Authorization to Release or Obtain Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Social Security # _____ Phone #: _____

Option #1

I AUTHORIZE COASTAL CARDIOLOGY TO **OBTAIN** MY MEDICAL RECORDS FROM THE FOLLOWING PHYSICIAN:

Physician: _____ Office Phone: _____

Office Fax #: _____

Option #2

I AUTHORIZE COASTAL CARDIOLOGY TO **RELEASE** MY MEDICAL RECORDS TO THE FOLLOWING PHYSICIAN:

Physician: _____ Office Phone: _____

Office Address: _____ City, State, Zip: _____

Office Fax #: _____

UNLESS INDICATED BELOW, ALL MEDICAL RECORDS RELEASED TO THE PHYSICIAN INDICATED ABOVE. THIS WILL INCLUDE LABS, OFFICE NOTES, OFFICE PROCEDURES OR TESTING PERFORMED IN THE OFFICE SETTING.

Treatment Dates from _____ to _____

Records may be faxed to: (843) 727-2973

Records may be mailed to: Coastal Cardiology, PA. 1033 St. Andrews Boulevard. Charleston, SC, 29407.

I understand my record may contain information related to acquire immune-deficiency syndrome (AIDS) or Human Immuno-deficiency infection (HIV), psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted disease, alcohol and/or drug abuse and this information will be released. _____ **(Initial)**

I understand that any disclosure of information carried the potential for re-disclosure and that the information must be in writing and that revocation of this release will not apply to information already based on this information. Revocation must be in writing. _____ **(Initial)**

This authorization will expire 12 months from the date of signature unless earlier date specified here: _____. _____ **(Initial)**

I understand there may be a charge for release of information and that under certain circumstances Coastal Cardiology contracts with an outside medical records vendor. In the event your request is processed by this vendor you will be billed directly prior to release.

_____ **(Initial)**

Signature of Patient of Legal Representative: _____

Print Your Name: _____

Date Signed: _____

<u>For office use only:</u>

Request Received by: _____ **Date:** _____

Signature: _____ **Date:** _____

Patient Chart # _____