Coastal Carolina Internal Medicine, PA

MEDICAL RECORDS REQUEST

Required for ALL authorizations for Release of PHI or Right to Access.

Patients Full Name: _____ Birth Date: _____

Social Security No. (last 4 digits) _____ Are these records for your own copy? ____Y ____N

Please release my medical records to:

COASTAL CAROLINA INTERNAL MEDICINE, PA
2420 Henderson Drive
Jacksonville, NC 28546
Ph (910) 937-0008

Purpose of Disclosure: _____
I authorize that the following information be sent to the address above:

___ Summary of my medical condition ___ Complete medical records

___ Copies of the information of my medical records described below. For period ___/___/___ to ___/___/___
Mo Day Year Mo Day Year

___ History & Physical ___ Test results ___ Emergency Room /Hospital records

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here ☐ ____

I understand that:
1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screening)
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
3. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that the information released will not include records from my other treating providers. I will contact them directly for the release of those records.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. Only if I request it, I can get a copy of this form after I sign it.

This authorization is valid for 365 days from the date of this request or until the date specified _____.

I have read the above and authorize the disclosure of the Protected Health Information as stated.

_____ _____
Signature of Patient /Patient representative (Authorized) Date

_____ _____
Print Name of Patient or Authorized Representative Relationship to Patient

CCIIM, PA STAFF WITNESS NAME/Initials: _____