COASTAL TIDES SURGICAL CENTER

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient:_____
(Last) (First) (Middle)

Patient's Date of Birth:_____SSN:_____Phone: _____

SPECIFIC INFORMATION TO BE DISCLOSED (check the appropriate box as needed):

☐ Billing Record *(Often used for Insurance Purposes)* ☐ Operative Note *(Often used for Insurance Purposes)*

☐ Clinical Abstract **(Fee for Copies: $1.00 per page up to 25 pages. Additional pages .25¢ each, per FL law)**

Other:_____

Dates of Service: _____

For the purpose of: ☐ Further Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other

This authorization will expire on:_____(If no date is specified, it will expire ninety (90) days after the date it was signed.)

☐ **I DO** ☐ **I DO NOT** authorize the release of information pertaining to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS)** or **AIDS related conditions**, and all medical records and clinical information relating thereto.

Initials of individual giving authorization: _____

☐ **I DO** ☐ **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health** or **psychiatric** conditions.

Initials of individual giving authorization: _____

☐ **I DO** ☐ **I DO NOT** authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related and/or alcohol-related** treatment.

Initials of individual giving authorization: _____

Releasing Party:
(Who has the information you need released?)

Coastal Tides Surgical Center
1002 N Arnold Road, Suite 401
Panama City Beach, FL 32413

Receiving Party:
(Who may receive the information? Where do you want the information sent?)

Name:_____
Method of Delivery: ☐Email: _____
☐Address: _____
_____

When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. The use or disclosure of the information identified above is voluntary and I need not sign this form to ensure healthcare treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my request, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information.

_____ _____
Signature of Patient or Patient's Representative **Witness**

_____ _____
Relationship to Patient *(if applicable, attach document of Guardianship or Power of Attorney)* **Date**

Phone Number: 448-212-0701 **Fax Number**: 448-212-0715