

GULF COAST MEDICAL SPECIALISTS, PLLC AUTHORIZATION TO RELEASE MEDICAL RECORDS

Name of Patient / Previous Names

Birth Date / Social Security Number

Street Address

City, State, Zip

AUTHORIZES:

RELEASE OF PROTECTED HEALTH INFORMATION TO:
GULF COAST MEDICAL SPECIALISTS, PLLC

Name of Health Care Provider

ATTN: _____

5831 Bee Ridge Road • Suite 210

Sarasota, Florida 34233

(941) 379-8481

Fax (941) 379-8142

Street Address

City, State, Zip Code

INFORMATION TO BE RELEASED:

I hereby authorize you to release **ALL** of my medical records for any treatment and laboratory/diagnostic tests performed **except for information pertaining to:**

Sexually transmitted disease

Testing or treatment of HIV/AIDS

Treatment of alcohol or substance abuse

Communications between patient and psychotherapist for mental health treatment

Records from other facilities/providers

For the Following Date(s) _____

PURPOSE FOR NEED OF DISCLOSURE: (check one)

Further Medical Care

Insurance / Eligibility

Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Gulf Coast Medical Specialists, PLLC, will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Gulf Coast Medical Specialists, PLLC, will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

SIGNATURE PATIENT / LEGAL REP: _____ **DATE:** _____

(If signed by other than patient, state relationship and authority to do so.)

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for six months from the date signed.