MEDICAL RECORDS RELEASE FORM

Coastal Cardiovascular Care
700 Garden View Court Suite 204
Encinitas, CA 92024
(Phone) 760-452-6334
(Fax) 760-634-9755

PATIENT INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Email Address _____

PLEASE SELECT ALL DOCUMENTS THAT APPLY TO YOUR REQUEST

- ☐ Complete Records
- ☐ History & Physical
- ☐ Progress Notes
- ☐ Care Plan
- ☐ Laboratory & EKG Reports
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Treatment Record
- ☐ Operative Reports
- ☐ Hospital Reports
- ☐ Medication Record
- ☐ Other _____

THE PURPOSE OR REASON FOR THIS RELEASE OF INFORMATION IS AS FOLLOWS

_____

RELEASE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FACILITY

☐ *Coastal Cardiovascular Care*
700 Garden View Court Suite 204
Encinitas, CA 92024
(Phone) 760-452-6334
(Fax) 760-634-9755

☐ Facility Name _____
Facility Address _____
Facility Phone _____
Facility Fax _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I _____ hereby authorize to release the requested information from my medical record, obtained in the course of my diagnosis and treatment. Including if appropriate psychiatric, alcohol, HIV care and drug abuse records to/from *Coastal Cardiovascular Care*.

Patient Signature _____ **Date** _____