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.

The information you may release subject to the signed release for is as following:

- ❑ Complete Records
- ❑ Care Plan
- ❑ Pathology Reports
- ❑ Hospital Reports
- ❑ History & Physical
- ❑ Laboratory & EKG Reports
- ❑ Treatment Record
- ❑ Medication Record
- ❑ Progress notes
- ❑ Radiology Reports
- ❑ Operative Reports
- ❑ Other (Please Specify) ____

Release my protected health information to the following physician/ facility/ entity:

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

The purpose/ reason for this release of information is as follows:

____

Signature:

____

Patient Name Date

____

Patient DOB

____

Signature of legal guardian/ representative Relationship Date