

PATIENT ACCOUNT #: _____

INTERCOASTAL MEDICAL GROUP, INC.
HYDE PARK WEST INTERNAL MEDICINE
2881 Hyde Park Street, 2nd Floor, Sarasota, FL 34239
Phone (941) 366-5440 Fax (941) 366-5793

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

I hereby authorize the use and/or disclosure of my protected health information:

FROM: Name of Provider/Facility: _____
Address: _____
Office Phone: _____ Fax: _____

TO: Name of Provider/Company/Person: _____
Address: _____
Office Phone: _____ Fax: _____

FOR A SPECIFIC PURPOSE CHECKED BELOW:

☐ Continued Medical Care ☐ Legal ☐ Changing Healthcare Providers ☐ Insurance
☐ Patient Request Other: _____

I authorize the following medical record(s) to be released (be specific and include dates-required):

State and federal law protect the following information. This information will be released unless you indicate otherwise below.

☐ NO Substance Use Disorder Records ☐ NO Sexually Transmitted Disease Records
☐ NO HIV/AIDS Records ☐ NO Psychotherapy Notes

I release and hold harmless Intercoastal Medical Group, Inc. and the physician's medical practice, members and employees, for all liability, including negligence, which may arise from complying with this authorization. I understand that any information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the rule. Under the Privacy Rules, I have the right to revoke this authorization at any time, and Intercoastal Medical Group, Inc. must cease using this authorization. However, Intercoastal Medical Group, Inc. may complete any actions it initiated prior to my revocation. I must revoke this authorization in writing and submit to the address listed at the top of this authorization. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

PROHIBITION ON REDISCLOSURE BY REQUESTOR:

This information is being disclosed from records whose confidentiality is protected. No further disclosure can be made without my specific written consent. A general authorization is not sufficient for this purpose.

AUTHORIZATION:

I acknowledge that I have read this authorization and fully understand its contents. This authorization is valid for one year from the date of execution.

PATIENT OR PERSONAL REPRESENTATIVE NAME (Please Print)

Relationship to Patient (if applicable)

SIGNATURE

DATE SIGNED

WITNESS SIGNATURE

DATE SIGNED

**Copy service fee may apply*