PATIENT ACCOUNT #: _____

INTERCOASTAL MEDICAL GROUP, INC.
RHEUMATOLOGY

5951 Cattleridge Ave, Sarasota, FL 34232
Phone (941) 366-3062 Fax (941) 957-1686

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 HIV/AIDS Records
___ NO Sexually Transmitted Disease 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*