COASTAL CAROLINA
CARE

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

NAME: _____
ADDRESS: _____
_____
PHONE:_____
Date of Birth:_____

RELEASE RECORDS FROM:

OFFICE:_____
ADDRESS: _____
_____
PHONE: _____
FAX: _____

RELEASE RECORDS TO:

Coastal Carolina Care
Carrie H. Thomas, PA-C
15441 US HWY 17 Ste 501
Hampstead, NC 28443
Phone : (910) 685 - 7307
Fax: (888) 964-2415

PLEASE RELEASE THE FOLLOWING RECORDS:

_____ Entire Chart	_____Pathology Reports	_____Emeregency Reports
_____History & Physical	_____Laboratory Reports	_____Discharge Summary
_____Progress Notes	_____Radiology Reports	_____Pharmacy/Prescription Records
_____Operative Notes	_____Cardiology Studies	_____Other_____

PURPOSE OF DISCLOSURE:

_____Transfer of Care _____Continuity of Care Other_____

Please place initials beside the options below to authorize the release of sensitive information pertaining to :

_____Mental Health	_____Drugs or Alcohol	_____Not Applicable: None of these apply
_____Genetic Testing	_____HIV/AIDS/Other Infectious Diseases	

Patient Signature (or Parent, Guardian or Legal Representative)

_____ _____
Signature Date