Coastal Medical Group

MEMORIAL SOUTHEAST PROFESSIONAL BLDG II.

11920 ASTORIA BLVD, STE 110
HOUSTON, TX 77089
PHONE # 281-464-8484
FAX # 281-464-8432

AUTHORIZATION

DATE: _____

TO: _____

PHONE #_____FAX#_____

I_____DATE OF BIRTH_____, HEREBY AUTHORIZE YOU TO TRANSFER OR MAKE AVAILABLE TO **Coastal Medical Group**

_____X-RAYS
_____PATIENT MEDICAL RECORDS
_____OTHER (listed below)

_____
AND ALL THE RECORDS AND REPORTS RELATING TO MY CASE.

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization ;and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

SIGNATURE OF PATIENT:_____

IF MINOR, NEXT OF KIN:_____

RELATIONSHIP OF MINOR:_____