HIPAA AUTHORIZATION TO RELEASE MEDICAL RECORDS

You are hereby authorized and requested to release to _____ any and all medical documentation, including, but not limited to records, reports, office notes, test results, or any other documents relating to my treatment at Coastal Therapy, Inc.

I have been advised of my rights under the Health Insurance Portability & Accountability Act, and have been provided notice that my records are being requested. You are further requested not to disclose any information from my medical file to anyone, other than the above listed, from this day forward, without my written authority to do so.

This_____day of_____, 201__.

_____
Patient Signature

_____
Witness