Coastal Spine and Rehab Center

Dr. Theresa Crandall, Chiropractic Physician
13910 Fivay Road, Suite 10, Hudson, FL 34667
Phone: 727-862-3509 Fax: 727-862-3500

Medical Records Release
Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____
Address: _____
_____
Phone: _____
SSN: _____ DOB: _____/____/____

I authorize the custodian of records or other person/entity named below to disclose/release the following information*:

- ☐ All records
- ☐ X-ray / radiology records and reports
- ☐ Lab / pathology records
- ☐ Billing records
- ☐ Pharmacy / prescription records
- ☐ Other:_____

Please send or fax the records listed above to:

Coastal Spine and Rehab Center
13910 Fivay Road, Suite 10
Hudson, FL 34667
727-862-3509 Phone
727-862-3500 Fax

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's representative) Date

_____ _____
Printed name of patient or representative Relationship to patient

This authorization is valid for one year from the date of signature.