Coastal Spine and Rehab Center

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Ph 727-862-3509 Fax 727-862-3500

Release of Patient Records Authorization

I hereby authorize _____to release a copy of my patient records or x-rays containing protected health information to:

Coastal Spine and Rehabilitation Center

This authorization is given pursuant to Florida Statute 456.057 and HIPAA regulations. I understand that Florida Statute 456.057(10) makes clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without the expressed written consent of the patient or the patients' legal representatives.

_____
(Patient's or Patient's Legal Representative's Signature)

_____ _____
(Patient's Date of Birth) (Date signed)

Specific description of information to be disclosed:

_____
_____
_____
_____

Release of Medical Information

I, _____, hereby authorize Coastal Spine and Rehabilitation Center. to release any medical information requested by representatives of local state or federal agencies, insurance companies, or other organizations or entities as may be required by said representative for payment of claims.

_____ _____
(patient/insured signature) (date)