COASTAL PULMONARY CARE

Attention: Medical Records

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please fax records to: 805-468-4495

Completion of this document authorizes the disclosure and/or use of your health information. Please read the following carefully and complete the requested information below. **There may be fees associated with your request.**

Name of Patient:_____ Date of Birth:_____

Other Names Used:_____ Telephone #:_____

I AUTHORIZE:_____
(Clinic or Provider)

Coastal Pulmonary Care, PHONE 805-460-6333

TO DISCLOSE TO:_____
(Persons/organizations authorized to receive the information)

8340 Morro Rd, Atascadero, CA 93422

AT THE FOLLOWING ADDRESS:_____
(Street, City, State and Zip Code)

THE FOLLOWING RECORDS,

☐ All Medical Records Available ☐ Other:_____

PURPOSE: For continuation of care.

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified:_____

I request these records to be delivered to Coastal Pulmonary Care by fax at **805-468-4495.** For questions, call Coastal Pulmonary Care at 805-460-6333.

MY RIGHTS:

- I have the right to be free from retaliation or other penalty for failing to sign the authorization
- I may revoke this authorization at any time, but I must do so in writing and submit to Coastal Pulmonary Care in writing.
- I have a right to receive a copy of this authorization.

SIGNATURE:_____ DATE:_____
(Patient or personal representative)