COASTAL PINES
MEDICAL GROUP

Attachment 10: **Medical Records Release**

Patient Name: _____ Date of Birth: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician(s)/person/facility/entity listed below.

The information you may release are as follows: complete medical records, care plan, pathology reports, Hospital reports, history & physical, lab reports, treatment record, medication record, prescription history, progress notes, radiology reports, and operative reports.

Release my protected health information to Coastal Pines Medical Group.

Print Patient/Member Name: _____

Signature: _____ Date:_____

Print Name of Person Signing (if other than the patient/member):

_____

Signature: _____ Date:_____