COASTAL PINES
MEDICAL GROUP

Medical Records Release Form

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.

Patient/POA Signature: _____

Date: _____

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Practices managed by Coastal Pines Medical Group.