MEDICAL RECORDS RELEASE
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name: ____ DOB: __________________

☐ I hereby authorize Coia Comprehensive Primary Care, LLC to **OBTAIN** any or all health care information pertaining to the above-named individual. I understand that this includes verbal communication as well as a copy of the medical record.

☐ I hereby authorize Coia Comprehensive Primary Care, LLC to **RELEASE** any or all health care information pertaining to the above-named individual. I understand that this includes verbal communication as well as a copy of the medical record.

Doctor and/or Facility Name: ____

Address: ____ City: __________________

State: ______ Zip code: ____________ Phone: ____________________ Fax: _____________________

I understand that the information in my medical record may contain mention of sexually transmitted diseases, HIV or AIDS. It may also contain information about behavioral or mental health services as well as treatment for drug and/or alcohol abuse.

This information is to be used for the purpose of continuity of care.

I understand that I have the right to revoke this authorization at any time in writing and that this revocation does not apply to information already released under the auspices of the existing authorization. Unless I specify an expiration date, event or condition, this authorization will expire in one year.

I understand that the disclosure of this information is voluntary. I can refuse to sign and it will not preclude my getting treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure.

____ ________________________
Signature of Patient or Representative Date

If signed by Representative, relationship: ____