*COASTAL MEDICAL GROUP*

150 EAST MEDICAL CENTER BLVD, SUITE D
WEBSTER, TEXAS 77598
PHONE # 281-990-9979
FAX # 281-990-9916

AUTHORIZATION

DATE: ______________________

TO: __________________________________________________

PHONE #____________________FAX#_____________________

I___________________________________DATE OF BIRTH________________, HEREBY AUTHORIZE YOU TO TRANSFER OR MAKE AVAILABLE TO **Coastal Medical Group**

______X-RAYS
______PATIENT MEDICAL RECORDS
______OTHER (listed below)

________________________________________________
AND ALL THE RECORDS AND REPORTS RELATING TO MY CASE.

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization ;and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

SIGNATURE OF PATIENT:___________________________________

IF MINOR, NEXT OF KIN:____________________________________

RELATIONSHIP OF MINOR:__________________________________