EMERALD COAST FAMILY PHYSICIANS
4785 N. 9TH AVE
PENSACOLA, FL 32503
PHONE: (850)476-9691 FAX: (850)476-0777

AUTHORIZATION TO RELEASE/OBTAIN HEALTH INFORMATION

I, _____ _____ _____
(Printed Name of Patient) *(Date of Birth)* *(Date of Service)*

Authorize Emerald Coast Family Care Physicians to disclose/obtain/medical/mental health information to/from the following person or agency:

Name of Physician or Hospital: _____

Address: _____

City/State/Zip: _____

This information includes:

☐ Psychiatric Assessment	☐ History & Physical Report	☐ Social Worker's History
☐ Treatment Plan	☐ Medications	☐ Billing information
☐ Discharge Summary	☐ Acute medical care record(s)	

☐ Other _____

This information that is being released may only be used for (check the appropriate boxes):
☐ Coordination/continuity of care.
☐ Coordination of the provision of other services that I may need.
☐ Payment/Insurance
☐ Other_____

This authorization is effective for 1 year from date of signature:_____
(Date)

I understand that:

1. I have the right to revoke this authorization at any time. I may not revoke it to the extent that Emerald Coast Family Physicians has already relied upon it.
2. I may only revoke this Authorization in writing to Emerald Coast Family Physicians. Please call Medical Record Department at (850) 476-9691 for assistance.
3. I have a right to inspect (or get a copy at my expense) of any information I authorize for disclosure.
4. Information used or disclosed under this authorization could potentially be re-disclosed for treatment purposes by the person receiving the information.

"This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains."

Signature of Patient: _____ **Date:** _____
(Parent or legal guardian/representative)

STAFF MEMBER INT:_____