COYLE INSTITUTE
Female Pelvic Medicine & Reconstructive Surgery

Medical Release Form

Patient Name: _____

Date of Birth: _____

AUTHORIZATION FOR RELEASE, USE, AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

Access Request to Copy/Inspect

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

Name of Facility	Phone Number
Address	Fax Number

2. The type of information to be used or disclosed is as follows (please include dates of service):

Medical Records

- ☐ Complete Medical Record
- ☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray, and imaging reports)
- ☐ History & Physical (H&P)
- ☐ X-ray and imaging reports
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Operative Report
- ☐ Laboratory Test Results
- ☐ Consultation Reports
- ☐ Immunization Record
- ☐ Other (List specific items) _____

Behavioral Health Report

- ☐ Social History
- ☐ Treatment Plan
- ☐ Client Data Form
- ☐ Academic History
- ☐ Referral/Treatment Form
- ☐ Aftercare Instructions
- ☐ Admission Evaluation
- ☐ Psychological Evaluation
- ☐ Notification of Admission
- ☐ Other (List specific items) _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or substance abuse.

   This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

COYLE INSTITUTE
Female Pelvic Medicine & Reconstructive Surgery

Medical Release Form

Patient Name: _____

Date of Birth: _____

5. This information may be disclosed to and used by the following individual/organization:

Coyle Institute
9295 Scenic Highway
Pensacola, FL 32514
Phone: 850.983.3528 | Fax: 850.983.3546

For the purpose of

☐ Further Medical Care ☐ Insurance Eligibility/Benefits ☐ Inspection/Copying of My Records
☐ Legal Investigation or Action ☐ Personal
☐ Changing Physicians ☐ Other (please specify): _____

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however, I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal, or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. Section 263(a)) and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #2 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

Signature: _____ Date: _____

Patient Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney for Health Care ☐ Authorized Legal Personal Representative

Identification: _____

Witness: _____ Date: _____

Include this form in the individual's records.