13910 Fivay Road, Suite 10
Hudson, FL 34667
Phone: 727-862-3509
Fax: 727-862-3500

Authorization to Transfer Medical Records

Date: _____

PATIENT INFORMATION

Name	
Address	
City, State, Zip	
Email Address	
Phone	

AUTHORIZED RECIPIENT

Name	
Address	
City, State, Zip	
Email Address	
Phone	

I, the undersigned, hereby authorize **Coastal Spine and Rehab Center** to release and transmit my medical information to the party named above.

SPECIFIC AUTHORIZATION: I hereby acknowledge that this release includes ALL medical information, including that protected by state or federal law such as substance abuse treatment, mental health treatment, and treatment and test results for sexually transmitted diseases including HIV/AIDS.

Patient Signature: _____ Print Name: _____

Relationship to Patient: _____ Date: _____