COASTAL FAMILY PRACTICE & ACUTE CARE CENTER, LLC

9961 EAST COUNTY HWY 30A SUITE 5
PANAMA CITY BEACH, FLORIDA 32413

OFFICE 850.231.9286
FAX 850.231.9287

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: Coastal Family Practice and Acute Care Center, LLC

Address: 9961 East County Hwy 30A Suite 5

City: Panama City Beach State: Florida Zip Code: 32413

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

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Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.