

Witness Signature/Printed Name

0 910.254.4818

F 910.254.4819

W CoastalBehavioralSciences.com

710 Military Cutoff Road Suite 120 Wilmington, NC 28405

Release of Confidential Patient Information

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	me:	Patient DOB://
I. Authoriza		
The Pr	oviders at Coastal Behavioral Sciences may use	e, exchange or disclose the following health care information,
writter	, electronic, faxed or oral form, please initial b	oxes next to information that can be released:
	Clinical/Psychiatric Initial Assessment	Medical History/Medication Management
	Service Notes/Content of therapy sessions	Treatment Plan
	Clinical Impressions	Alcohol/Drug Treatment Information*
	Psychological Evaluation	Other:
	My health information for the following	dates only:
I. Authorized	Parties.	
		pove) may use, exchange or disclose my above authorized hea
care in	formation, in written, faxed or oral form with:	50 vo, may use, exchange of this lose my above authorized her
	address, phone & fax number, if available, of p	ovider/organization/individual
ı tanıc,	actions, phone to tax number, it available, or p.	ovider/organizacion/individual:
П. Reason(s) f	or Release of Information:	· · · · · · · · · · · · · · · · · · ·
o At	my request to coordinate ongoing treatment with	h my other health care providers
o At	my request to supply my medical records to:	
O At		
o Otl	her:	
o Oti	ner:	
Otl • V. My Rights	her:	
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