Coastal Mental Health Center, Inc.

Jacksonville
8382 Baymeadows Road
Suite 7
Jacksonville, Fl 32256

Leesburg
8136 Centralia CT
Suite 101
Leesburg, FL 34788

Orange City
300 Treemont Drive
Orange City, FL 32763

Sanford
101 Bellagio Circle
Sanford, FL 32771

Orlando
1320 N. Semoran Blvd
Suite 107
Orlando, FL 32807

Daytona
801 Beville Rd
Suite 202A
South Daytona, FL 32119

Saint Cloud
2900 17th Street
Suite 3
Saint Cloud, FL 34769

Palm Bay
5200 Babcock Street NE
Suite 105
Palm Bay, FL 32905

Rockledge
1282 Rockledge Blvd
Suite 2
Rockledge, FL 32955

AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE OF ADMISSION: _____ SOCIAL SECURITY: _____

I hereby authorize Coastal Mental Health Center to ☐RELEASE or ☐OBTAIN information by mail, courier or facsimile (fax) transmittal to/from:

PERSON OR ORGANIZATION: _____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

The following information is to be disclosed:

☐Entire Medical Records ☐ Lab Tests / X-rays ☐History & Physical Examination
☐IEP / School Records ☐ Other: (specify) _____

(Psychotherapy notes are excluded)

For the purpose of: ☐CONTINUING CARE ☐PERSONAL ☐OTHER _____

(Psychotherapy notes are excluded)

NOTICE TO PATIENT AND RECIPIENT OF RECORDS

I understand that this form may be used to release information related to mental health treatment. I further understand that the information disclosed may include psychiatric, drug/alcohol abuse and/or HIV data.

I understand that I have the right to refuse to sign this Authorization or to rescind my consent at any time prior to the release of the information. If I do not revoke this authorization it will automatically expire 60 days from the date of signature unless otherwise noted below. The consent is effective beginning on _____, and expires on _____, if not earlier revoked.

_____	_____	_____
PATIENT'S SIGNATURE	PRINTED PATIENT'S NAME	DATE / TIME

_____	_____	_____
When applicable, Signature of: ☐ Parent ☐ Guardian ☐ Guardian Advocate ☐ HealthCare Surrogate/Proxy ☐ Personal Representative/Equivalent (if deceased) ☐ Power of Attorney	When applicable, Printed Name of: ☐ Parent ☐ Guardian ☐ Guardian Advocate ☐ HealthCare Surrogate/Proxy ☐ Personal Representative/Equivalent (if deceased) ☐ Power of Attorney	DATE / TIME

_____	_____	_____
Signature of Witness	Printed Name of Witness	DATE / TIME

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