Gulf Coast Behavioral Clinic

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GCB Clinic
Accept No Limitations!
We Offer Hope , Kindness & Support

Authorization to Release Medical Information

I, _____, hereby authorize (check all that apply):
Name of Patient/Legal Guardian

☐ Gulf Coast Behavioral Clinic ☐ Other: _____

To release and/or disclose the following medical information (check all that apply)

☐ All Records (including Psychiatric Evaluations) ☐ Academic Testing Results/School Records

☐ Diagnosis and Medication List ☐ Past and Future Appointments

☐ Other: _____

For the following patient/individual:

☐ Myself ☐ Child/Individual under my legal guardianship

To the following healthcare providers/agencies/individuals:

☐ Gulf Coast Behavioral Clinic ☐ Spouse: _____

☐ Other: _____

I understand that authorizing the disclosure of this information is voluntary. I may revoke this authorization at any time by submitting a request in writing to Gulf Coast Behavioral Clinic.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient/Legal Guardian Date