Coastal Mental Health Center
526 W Lake Mary Blvd
Sanford, Florida 32773
(P) 800-614-4124
(F) 888-217-4124

GENERAL AFFIDAVIT

Patient Name: _____

Guardian Name: _____

Coastal Mental Health Center will provide medical records upon request complying with HIPPA medical release form on file per patient. Coastal Mental Health Center professional and administrative staff will not be accessible to appear in court proceedings pertaining to the patient and/or provide psychotherapy notes. Arrangements can be made accordingly at the time of event, if needed a letter from our facilities will be provided.

Patient (patient guardian) _____, makes this his/her statement and General Affidavit upon affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of his/her knowledge:

1. Are you involved in any court cases? Yes No

2. If so please give details:

_____

_____

_____

3. Are you currently seeking treatment court ordered? Yes No

4. If so please give details:

_____

_____

_____

Patient Signature: _____ Date: _____

Physician: _____ Date: _____

Witness: _____ Date: _____