Coastal Psychiatric Urgent Care

HIPAA Authorization for Release of Protected Health Information (PHI)

Patient Name: _____
Date of Birth: _____

1. Authorization to Disclose Health Information
I authorize the healthcare provider or facility listed below to release my protected health information (PHI) to the individuals named below.

Provider/Facility Name: _____
Phone/Fax: _____

2. Individuals Authorized to Receive Information
I authorize the release of my health information to the following person(s):

Name	Relationship	Phone Number

3. Type of Information to Be Disclosed
I authorize the release of (check all that apply):
☐ All health information, including diagnosis, treatment, and billing
☐ Appointments
☐ Specific information (describe): _____

4. Consent for Communication Preferences
☐ You **may** leave detailed messages (e.g., diagnosis, test results) on:
☐ Home Voicemail ☐ Cell Voicemail ☐ Work Voicemail

☐ You **may NOT** leave detailed messages on any voicemail
☐ Call only me directly to discuss personal health information

Patient Signature: _____
Date:_____