

RELEASE OF MEDICAL INFORMATION

Patient's Name: _____
Last First M.I. Maiden

Birth Date: _____ **Social Security Number:** _____

Address: _____

Phone: _____

I hereby authorize Coastal Surgical Specialists, P.C. to release my medical information to the physician, health care facility, insurance carrier or agency listed below.

To: _____

Signature of Patient or Guardian

Date

Authorization is effective until revoked by the patient.