

Smith, William Scan on 6/23/2021 by Brittany D. Francis of cmg

Coastal Medical Group
Partners | PRIMARY HEALTH

300 S. Greene Road
Fairhope, AL 36532

Release of Information (ROI) Authorization Form for Use and Disclosure of Protected Health Information (PHI)

Patient Last Name Smith Patient First Name William Middle Initial C

Date of Birth 10/11/62 Social Security Number 424-62-5653 Patient MRN _____

1. I hereby authorize the following person/entity:
Lindsey Barton
Name of entity/individual/class of persons
7461 East Drive
Address City, State, Zip Montgomery AL 36117

PHN (334) 244-3281 Fax (334) 244-3386

To release to:
☒ CMG/Dr. Dukes - Fax: 251-929-0545
☐ CMG/Tara McDonald, CRNP - Fax: 251-990-0351
☐ CMG/Dr. McDuff - Fax: 251-990-0355
☐ CMG/Dr. Minto - Fax: 251-990-0357

2. I authorize the following to be released for the date(s) of service: ALL
☒ All medical records ☐ X-rays ☐ EKG ☐ Lab Results ☐ Other

3. I authorize this information to be released for the purpose(s) of:
☐ Continuity of Care ☒ Change of PCP ☐ Insurance Claim ☐ Personal Use ☐ Legal Use

By signing below I am giving authorization to release to/from IMC-Coastal Medical Group my protected health information including medical, psychiatric, alcohol, HIV, drug abuse, and/or financial information contained in my records.

This authorization will expire 1 year from the date of signing below unless specified otherwise. (Date of expiration if different: ____/____/____). I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to IMC-Coastal Medical Group.

I understand that I am not required to sign this form in order to receive treatment from IMC-Coastal Medical Group.

Signature of Patient [Signature] Date 6/23/21

Signature of Facility Representative [Signature] Date 6/23/21