Patients Name

C.O.A.S.T. Rehabilitation Services

AUTHORIZATION FORM FOR USE & DISCLOSURE OF HEALTH INFORMATION

To All New and Established Patients:

COAST Rehabilitation Services is required by law to maintain the privacy of our patient's health information. Unless you have signed a form authorizing the use or disclosure: we will not use or disclose your health information for any purpose other than COAST's role in treatment, payment or for health care operations. With your written approval, we may disclose your health information to others including designated family, friends, or others who are involved in your health care or in payment for your health care. This form allows you to designate this/these person (s). A copy of this form is as valid as the original.

I, _____, hereby authorize the use or disclosure of health information about me as described below. As the parent/guardian I authorize the use or disclosure of health information about my minor dependent

_____

Dependents full name Date of Birth

1. Person or group authorized to disclose information:

   COAST Rehabilitation Services

2. Person or group authorized to receive and use information from **COAST Rehabilitation Services**

   Current insurance provider (s)

   *Spouse*_____

   Family/Friends _____

   Please provide name, address and relationship