



COASTAL
BEHAVIORAL
SCIENCES

O 910.254.4818
F 910.254.4819

710 Military Cutoff Rd, Suite 120
Wilmington, NC 28405

Robert M. Adams IV, MD
Psychiatrist

Kimberly S. Adams, PsyD, ABPP-CN
Neuropsychologist

Carol Lockman, FNP
Family Nurse Practitioner

Linda Burbank, LCSW
Psychotherapist

Morgan Lankford, MS, CRC, LPCA
Rehabilitation Counselor

**Release of Confidential Patient Information
&**

Authorization for Coastal Behavioral Sciences (CBS) to Use & Disclose confidential Patient Health Information

Patient Name: _____ **Patient DOB:** _____ / _____ / _____

I. Authorization:

The Providers at Coastal Behavioral Sciences (listed above) may use, exchange or disclose the following health care information, in written, faxed or oral form *:

- All my health information maintained by Coastal Behavioral Sciences
- The following health information only: _____
- My health information for the following dates only: _____

*This authorization ends when I contact Coastal Behavioral Sciences *in writing* and revoke my authorization.

II. Authorized Parties:

The Providers at Coastal Behavioral Sciences (listed above) may use, exchange or disclose my above authorized health care information, in written, faxed or oral form with:

Name, address, phone & fax number, if available, of provider/organization/individual:

III. Reason(s) for Release of Information:

- At my request to coordinate ongoing treatment with my other health care providers
- At my request to supply my medical records to: _____
- Other: _____

IV. My Rights:

I understand that I do not have to sign this authorization for release of information in order to receive treatment at Coastal Behavioral Sciences, unless my provider(s) at CBS feel that without such information, they cannot safely and legally offer me mental health care. I understand that I may revoke this authorization at any time by submitting such a request for revocation in writing, though this revocation will not apply to information already disclosed prior to the revocation. I understand that the providers at CBS are not responsible for how my health care information is used once it is released from their office per my request. I hereby release each and every provider and staff person at Coastal Behavioral Sciences from any and all liability that may arise from the release of my confidential healthcare information for its specified purpose. This release is, to the best of my knowledge and the knowledge of the staff and providers at CBS, to be HIPAA compliant.

Signature of Patient or Legal Guardian

Date signed and accepted

Printed Name of Patient or Legal Guardian

Witness Signature

I hereby revoke the above Release & Authorization for all my confidential patient information.

Signature of Patient or Legal Guardian

Date signed and accepted

Printed Name of Patient or Legal Guardian

Witness Signature