COASTAL IMAGING & VASCULAR ASSOCIATES
A division of Coastal Radiology Associates

1165 Cedar Point Blvd
Cedar Point, NC 28584
Phone: 910-353-3759 Fax: 252-393-1076

Authorization to Release Health Information

Patient Information:

Name of Patient _____Date of Birth _____

Address_____

City, State, Zip _____ Phone _____

At my request, _____may release the following information:

- ☐ Entire Medical Record
- ☐ Financial records
- ☐ Office visit notes
- ☐ Marketing*
- ☐ On-site record review by the patient
- ☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
- ☐ Diagnostic studies (list): _____
- ☐ Other as listed: _____

*Financial compensation was received for this communication.

Entity or person who will receive the information:

Name: Coastal Imaging & Vascular

Address: 1165 Cedar Point Blvd, STE I

City, State, Zip: Cedar Point, NC 28584 Phone: 910-353-3759 Fax: 252-393-1076

Delivery Method: ❑ US Mail ❑ Fax

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Revised 5/14; 3/15; 9/16; 8/17; 3/24/2026