Gulf Coast
Medical Management
"We're right where you want us to be"

Gulf Coast Medical Management Authorization to Release Patient Information

Instructions: Please complete the form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. The release is not valid unless signed and dated by patient or legally authorized representative.

☐ I AUTHORIZE _____ _____TO DISCLOSE/RELEASE THE INFORMATION
Name of Provider/Facility
BELOW TO GULF COAST MEDICAL MANAGEMENT.

Patient's Name: _____
Last First MI
Previous Name if Applicable: _____

Patient's Birth Date: _____/_____/_____ Patient's Social Security #: _____ - _____ -_____

Patient's Phone Number: ( ) _____

THIS INFORMATION IS TO BE DISCLOSED/RELEASED TO:

Anne Weidler, P.A.
Chronic Disease Case Manager
Gulf Coast Medical Management
1700 S. Tamiami Trail
Sarasota, FL 34239
Fax: (941) 917-2956

INFORMATION TO BE RELEASED:

I hereby authorize you to release all medical records for any treatment and laboratory/ diagnostic tests performed except for information pertaining to:

☐ Sexually transmitted disease
☐ Treatment of alcohol or substance abuse
☐ Testing or treatment of HIV/AIDS
☐ Communications between patient and psychotherapist for mental health treatment

For the following dates: All Inclusive

PURPOSE FOR NEED OF DISCLOSURE: (check one)
☐ Further Medical Care
☐ Other (Specify): _____

POSSIBILITY OF RE-DISCLOSURE: I understand that any information released may be subject to re-disclosure and no longer protected by state and federal regulations.
EXPIRATION AND REVOCATION: I understand that this authorization is valid for 6 months from the date I sign it, or until _____(date/event). I have the right to revoke this authorization in writing at any time. The revocation will take effect on the day it is received except to the extent it has already been acted upon or if the authorization was obtained as a condition of obtaining insurance coverage.

_____ Date: _____/_____/_____
Signature of Patient or Legally Authorized Representative
If other than patient signing, state relationship: _____

_____ Date: _____/_____/_____
Signature of Witness