Reset Form Print Form

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Bay Street MEDICAL
LIVING ON THE HEALTHIER SIDE OF LIFE

Patient Name _____ Date of Birth _____
Address _____
Bay Street Medical Record Number _____ Daytime Telephone Number _____

I hereby authorize Bay Street Medical ("BSM") to disclose the following Protected Health Information pertaining to the above referenced patient to:

Name of Person or Entity _____
Address _____
City, State, Zip Code _____

☐ Mail*
☐ Pick-up at*
☐ Clinic
☐ Fax or E-Mail
☐ Date/Time _____

Purpose for release of information: ☐ Personal ☐ Continuing Patient Care ☐ Other _____
*Charges may apply for copies delivered directly to the patient.

Information being requested, please specify (i.e., Physician/Provider/Service or Dates of Service or Records/Reports) **(for images, see below)** :

_____

_____

If above section is not completed, responses to records requests will contain a record abstract of the most recent notes and results. This will include:

- For hospital records - History and Physical, Discharge Summary, Operative/Procedure Reports, Emergency Department Report, Consultation Report and test results.
- For clinic/outpatient records - Physician or midlevel provider visit notes, Operative/Procedure Reports and test results.

Billing statements needed: ☐ Yes

FOR IMAGES/FILMS

Radiology Records needed (includes radiology report and image in electronic format):

☐ Mail*
☐ Pick-up at*
☐ Clinic
☐ Hospital/ Imaging Facility
☐ Date/Time _____

EXAM DATE	EXAM DESCRIPTION	EXAM DATE	EXAM DESCRIPTION

I understand this authorization covers records relating to communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such records exist.

I understand that Bay Street Medical will not condition treatment on whether I sign this Authorization.

I understand that I have the right to revoke this authorization at any time except to the extent that Bay Street Medical has already taken action in reliance on it. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the mail address below. I understand that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that receives the information.

I understand that this authorization will expire one (1) year from the date of signing unless specified below:

Desired Expiration Date _____

_____ _____
Signature

_____ _____
Print Name Relationship to Patient (if not patient)