BAYSHORE WOMENS HEALTHCARE

BOARD CERTIFIED IN OBSTETRICS & GYNECOLOGY

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

By my signing below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by the federal privacy regulations.

PATIENT'S NAME:	DOB:	SOCIAL SECURITY #:

PERSONS/ORGANIZATIONS PROVIDING INFORMATION:	PERSONS/ORGANIZATIONS RECEIVING INFORMATION:

PURPOSE OF THIS RELEASE: □ PERSONAL USE □ LEGAL PURPOSES □ CONTINUITY OF CARE
□ INSURANCE PURPOSE □ OTHER ____________________

TYPE OF INFORMATION TO BE RELEASED:
□ PROGRESS NOTE □ HOSPITAL RECORDS □ RADIALOGY REPORTS
□ LAB REPORT □ HISTORY AND PHYSICAL □ ENTIRE MEDICAL RECORD
□ OTHER ____

I have been informed that there may be benefits or disadvantages to releasing this information. This authorization shall be valid for six months from the date of signature or from date of completion of treatment whichever is later, unless otherwise specified or expressly revoked by patient in writing prior to that time. I understand that the policy requires payments of $1.00 per page copying fee for Medical Records. If the records are mailed to a physician or another medical facility, there will also be a copying fee charged. We require a minimum of 72 hours to process any request.

DATE UPON WHICH AUTHORIZATION EXPIRES: ______________________ (If left blank will expire in six months)

____
Patient Name **Date**

____
Patient Signature **Date**

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