BAYSIDE ORTHOPAEDIC
SPORTS MEDICINE & REHAB CENTER

P.O. Box 1186 Fairhope, AL 36532 Phone: 251-928-2401 Fax: 251-928-5099

AUTHORIZATION FOR RELEASE OF INFORMATION

Name:____

Address:____

City,State,Zip:____

Phone :(____)_________________ Date of Birth:_________________ SSN:_______________________

I hereby authorize **Bayside Orthopaedic, Sports Medicine & Rehabilitation Center** to release my records to:
____

____

(Name and Address of person/place to be released to)

*******This consent and authorization may include, but is not limited to the release of medical, psychological, psychiatric, alcohol, drug abuse, and HIV/AIDS information.********

Reason for the request:____

***** (If you want all the records to be released please Initial on the line next to ALL records to be released.)*****

_______All records to be released

_______Records as of (enter date):________________________________

_______Complete records regarding treatment in connection with: ________________________________

OR

Specific information. The specific information to be released includes: (Please check all that apply.)

____Progress notes ____X-ray films/CD/reports ____History and Physical
____Nurses' notes ____Lab/Path reports ____Operative reports
____Physical Therapy notes ____MRI/CT reports ____Discharge Summaries
____Physicians' orders ____Bone Scan reports ____Consultations
Other (please describe):____

I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereon, and that this consent will remain in force for one year unless otherwise noted here.
(enter term of consent if other than on year:____)

Signature of Patient/Representative:____Date:___________

Relationship if not patient:____

Signature of Witness:____ Date:___________
Any disclosure of medical record information by the recipient(s) is prohibited except when implicit in the purposes of this disclosure.

________ Date request received ________ Date request completed ________ Date records picked up