

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Phone : (____) _____ Date of Birth: _____ SSN: _____

I hereby authorize: _____

(Name of Healthcare Facility)

to release my records to: **Bayside Orthopaedic, Sports Medicine & Rehabilitation Center**

P.O. Box 1186 Fairhope, AL 36532

Phone: 251-928-2401 Fax: 251-928-5099

******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-rays on CD/films/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.

_____ First request

_____ Second request

_____ Third Request

