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