Last Name: _____

First Name: _____

DOB: Phone:

BAYVIEW

Release of Medical Information

I hereby authorize: _____ (Facility)

and their staff to release medical records for the following individual: _____

Date of Birth: _____ SSN: _____

Please release to: _____

_____

_____

- ☐ All Medical Records
- ☐ Office Notes
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Lab / X-ray Data
- ☐ Psychiatric/Psychological Information
- ☐ Operative Report(s)
- ☐ Diagnostic Studies
- ☐ Other: _____
- ☐ Other: _____

This authorization will expire in : ☐ 60 days ☐ 90 days ☐ Other _____

For the specific purpose of: _____

I authorize release of my medical records and other information regarding my treatment including, but not limited to, psychological or psychiatric impairment, drug abuse, alcoholism, sickle-cell anemia, acquired immunodeficiency syndrome (AIDS), or test for infection with human immunodeficiency. I authorize the Facility listed above to furnish the requested information, even though the confidentiality of the information may be protected by Federal or State Law.

I understand that this authorization is voluntary. I understand that the ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.

The Facility listed above and its staff are hereby released and discharged from any liability. I will hold the Facility listed above and its staff harmless for complying with this authorization to release medical information.

Authorization can be revoked, but the withdrawal of authorization cannot be retroactive to release of information made in good faith.

I understand that I have a right to inspect and receive a copy of the information described on this form.
I certify that I have received a copy of this authorization.

Patient Name	Patient Signature	Date
Witness Name (Print)	**Witness Signature**	

If the above patient is under the age of 18 and/or has a legally appointed guardian, this release must be signed by his/her parent or guardian. Proof of guardianship may be required in some cases.

Patient (or Guardian) Name (Print)	Patient (or Guardian) Signature	Date
Witness Name (Print)	**Witness Signature**	