Last Name: _____ First Name: _____ DOB: Phone:	BAYVIEW

Release of Medical Information

I hereby authorize: _____
(Facility) and their staff to release medical records as requested below.

Please release to: _____

_____

_____

_____

Information contained in the medical record of:

_____ _____
Patient Name (please print) Birthdate

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

Covering the period of time from: _____ to _____
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.

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 will expire 60 days from date signed unless specified otherwise. Authorization can be revoked, but the withdrawal of authorization cannot be retroactive to release of information made in good faith.

Patient Name (Print)	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**	