Bayspring Medical Group
INTERNAL MEDICINE & GYNECOLOGY

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Phone (415) 674-2600 Fax (415)674-2601

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Name: _____
Last First Middle

Home Address: _____
Street City State Zip

Phone #: _____ Date of Birth: _____

I hereby authorize _____ to disclose/release the following information * (check all applicable):

☐ All Records ☐ Abstract/Summary ☐ Laboratory/Pathology Records

☐ Pharmacy/Prescription Records ☐ Radiology Records ☐ Billing Records

☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheet if necessary):

1) Name: _____

Address: _____
Street City State Zip

Phone #: _____ Fax#: _____

2) Name: _____

Address: _____
Street City State Zip

Phone #: _____ Fax#: _____

The information may be used/disclosed for each of the following purposes:

☐ At my request (only the patient can check this box) ☐ For employment purposes

☐ For my health care ☐ For payment/insurance

☐ Other (describe specifically) _____

This authorization shall become effective immediately and shall remain in effect until (enter specific date): _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment: receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that there will be a fee $15.00/$25.00 to copy records.

Signature: _____ Date: _____