BAY AREA PHYSICIANS *for* WOMEN

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MEDICAL RECORDS RELEASE AUTHORIZATION
(MUST RESPOND WITHIN 30 DAYS)

I, _____ , do hereby authorize the release of and/or
(PRINT PATIENT'S NAME)

permission to obtain any Protected Health Information (PHI).

Patient's Date of Birth: _____ Patient's Soc Sec #: _____

Patient's Address: _____

_____

Patient's Home Phone #: _____ Work or Cell #: _____

FROM _____ Ph#: _____ Fax#: _____
(PRINT PHYSICIAN'S NAME OR PRACTICE NAME)

TO _____ Ph#: _____ Fax#: _____
(PRINT PHYSICIANS'S NAME OR PRACTICE NAME)

Request records from the dates of _____ to _____

Are you transferring your care to another physician? _____ Yes _____ No

Please release information for office visits, labs, ultrasound, x-rays, and original referring physician records. Medical records may contain information concerning psychological drug, and/or alcohol conditions and/or diagnosis, treatment and care of same; and/or diagnosis, treatment and care of sexually transmitted diseases or complications related to sexually transmitted diseases including but not limited to HIV testing and test results. I hereby authorize the release of such medical records pursuant to this authorization for release, and waiver of confidentiality provisions, pertaining to this release.

This Authorization will expire _____ (mm/dd/year), not to exceed twelve (12) months.

By signing below, I understand that the PHI to be disclosed may be subject to redisclosure by the recipient of the PHI and no longer protected by the federal Privacy Rules, and that I may revoke this authorization at any time by notification in writing, but it will not have any effect on uses or disclosures of PHI prior to the receipt of the revocation.

_____ _____
PATIENT'S SIGNATURE DATE

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