BayChoice Bariatric & Laparoscopic Surgery
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Authorization for Release of Medical Records

Patient Name ______________________ Date __________

Address ______________________ SS# __________

______________________ DOB __________

Receive Records from:

____
____
____

Release Records To (Only items on BayChoice letterhead will be released; all other records must be obtained from original source):

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Please send a copy of my records as indicated for date(s) of Treatment: __________

______ Operative Records ______ Lab Records ______ H&P ______

______ X-Ray Reports ______ Prenatal Records ______ Discharge Sum

______ Other

Purpose for releasing medical information ______________________

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Signature of Patient, Parent or Legal Guardian

____
Witness

____
Date

I understand that my express consent is require to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentially is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

______________ ______________ ______________
Signature Witness Date

Permission to FAX records for medical emergency? ______ Yes ______ No