BAY CLINIC, INC.

NETWORK OF FAMILY HEALTH CENTERS

Authorization for Release of Information

RECEIVE RECORDS

Patient Last Name:	Patient First Name:	Middle Initial:

Maiden or Other Name	Birthdate:	Social Security #:

Mailing Address:	City:	State:	Zip:

Home phone #:	Work phone #:	Cell phone #:

I hereby authorize:

Name			
Address:	City:	State:	Zip:
Phone:	Fax:		

To: □ SEND □ SHARE (DISCUSS) □ SEND/SHARE (DISCUSS)
with Bay Clinic, Inc.
Please mail or fax information to:

INFORMATION TO BE RELEASED:	DATES:
□ OV – last year	________________
□ Most recent labs	________________
□ Last mammogram	________________
□ Last colonoscopy	________________
□ Last hospitalization within 2 years	________________
□ Most recent immunization list	________________
□ Imaging test results for the last year	________________
□ Most recent ECG	________________
□ Dental Notes	________________
□ Dental X-Ray	________________
□ Other:	________________

I specifically authorize the release of information relating to:

	Please Initial:
□ Substance Abuse (including alcohol/drug abuse)	________
□ Mental Health (including psychotherapy notes)	________
□ HIV related information (AIDS related testing)	________

X____________________________________ ______________
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: □ Changing Physicians □ Consultation/Second Opinion □ Continuing Care
□ Legal
□ Other (please specify): ____

1. This authorization is valid for release of Protected Health Information for 180 days from the date below OR as indicate:
□a one-time disclosure □upon termination from services □until revoked □Other: ________________________________
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].
4. I understand that in compliance with State of Hawaii § 622-57 (g), I will pay a fee of $______________(Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

______________________________ __________ OR ______________________________ __________
SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

______________________________ __________ ______________________________
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED:______________________________ BY: ______________________________

IDENTIFICATION PRESENTED:__________________________ FEE COLLECTED: $____________