BAYSIDE FAMILY MEDICINE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Address: _____ City: _____ State ____ Zip _____

Date of Birth: _____ Phone #: _____

I hereby authorize **Doctor:** _____
Address: _____
Phone #: _____

to release my health information listed below to Bayside Family Medicine Fax: (814)877-5882
510 Cranberry Street, Suite 200 Phone: (814)877-5274
Erie, PA 16507

Specific records to be released and time period:
☐All records including, but not limited to immunizations, general health records and pap smears. –or-
☐ Specific records: _____
For the following period: _____

The purpose of need to release these records is for: (must be filled in)*****
_____ Continuation of care _____ Billing or Insurance processing _____ Other _____ (please list)

I specifically authorize the disclosure of the following type(s) of information, if it is included within the information requested above:
☐Mental Health _____ (initials) ☐Drug and /or Alcohol Abuse/Treatment _____ (initials) ☐HIV Status _____ (initials)

This authorization will expire one year from the below date.

I understand that I have the right to revoke this authorization at any time. I may not revoke it to the extent that Hamot has already relied upon it, or if this authorization was signed as a condition of obtaining insurance coverage. In order t revoke this authorization, I understand that I must revoke it in writing to Hamot Medical Center. Hamot Medical Center has forms for you to use if you wish to revoke this authorization at any time before it expires.

I understand that information used or disclosed by Hamot Medical Center to any other person(s) under this authorization could potentially be re-disclosed by the person(s) receiving the information, and may no longer be subjec to the privacy protections provided to me by law.

I understand that Hamot may not require that I sign this Authorization in order to obtain treatment.

Date: _____ Signature: _____

If you are the legal representative of the person listed above, please circle the basis for your authority and attach proof of authority:
Power of Attorney Guardianship Order Parent of Minor Executors/Administrator Other: _____

_____ _____
Signature of Legal representative of patient above Date Signed