BayCare
Medical Group

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Patient's Legal Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

I authorize the following **BayCare Medical Group** office,

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

To ☐ Disclose and/or ☐ Obtain my medical records from:

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Via: ☐ Patient Portal (Must have BayCare Patient Portal Account)

☐ Paper (I understand that all records will be mailed unless I coordinate to pick up in person)

The purpose of this request: ☐ Personal ☐ Treatment (continued care) ☐ Other: _____

Please furnish the following information specified for the following visit dates: _____ Check all appropriate boxes below.

☐ Office Notes ☐ Laboratory Results ☐ EKG ☐ Radiology Results

☐ Complete Record ☐ Other (please describe):_____

I understand that the protected health information specified below may include mental health substance abuse (drugs, alcohol), HIV/AIDS status information, diagnostic and treatment records. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility listed on the authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature: _____ Date: _____

Patient or Authorized Person: ☐Parent ☐Legal Guardian ☐Executor ☐Power of Attorney

Witness: _____ Date: _____

Please return the completed authorization one of the following ways: by faxing it to 858-244-3543; or by emailing it to BMGMedicalRecordRequest@baycare.org or returning it to your BMG practice.

RELEASE OF INFORMATION AUTHORIZATION - BMG
BC 2958 Rev. 12/18

PATIENT

NAME:_____

DOB:_____

MRN / FIN: _____