Bay Women's Health
308 Hospital Drive, Suite 101
Glen Burnie, MD 21061
Phone: 410-595-6353
Fax: 410-595-6661

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ D.O.B: _____

Address: _____

_____

Phone: _____ Alternate Phone: _____

_____

I authorize _____ to release my complete health record

(including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of

alcohol or drug abuse) to _____.

I understand that this medical information may be used by the person I authorize to receive this information for medical treatment and consultation and any other purposes that I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature: _____ Date: _____

(This authorization will expire one year to the date of above signature)