North Bay Medical Associates, P.A.

Authorization for Release of Information

Patient Name: _____

Last First MI

Maiden or Other Name: _____ DOB: _____

I hereby authorize _____ (print name of provider) to release my medical record and/or items checked below to:

North Bay Medical Associates, P.A.

(Below lines are for **Office Use** to dictate which facility is requesting records.)

_____

_____

_____

_____

_____

Information to be released: Date(s):

- ❑ Medical Record _____
- ❑ X-rays _____
- ❑ EKG _____
- ❑ Itemized Statement _____
- ❑ Other: _____ _____

Purpose of Disclosure:

_____

_____

- I understand that this authorization will be valid for one year.
- 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.
- I understand that information disclosed to the above individual or organization may be redisclosed and not protected by the Federal privacy regulations.
- I understand that my right to receive medical services from NBMA will not be affected if I refuse to sign this authorization.
- I understand that if my record contains information related to substance abuse, HIV related information and/or mental health information, that information will be released with my medical record.

_____ _____

Signature of Patient/Legal Guardian/Representative Date

_____

If signed by someone other that the patient, state the relationship and/or reason and legal authority to do so.