



Your center of excellence
for patient-focused healthcare

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Previous Name: _____ Social Security#: _____

I request and authorize *Bay Internists, Inc.* to release the healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

All healthcare information

Healthcare information relating to the following treatment, condition, or dates:

Other:

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED