Baywell Psychiatry Group

Administrative Office
582 Market Street, Suite 812
San Francisco, CA 94104
Tel 415-922-9122
Fax 415-920-9925
www.baywellpsych.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize **Baywell Psychiatry Group** to release medical records to:

DISCLOSE TO:

Name of Person or Facility:	Phone:
Address:	Fax:
City: State: Zip Code:	Email:

THE PROTECTED INFORMATION OF:

Name of Patient:	Date of Birth:
Address:	Phone:
City:	Email:
State: Zip Code:	SS#:

FEE: We charge 25 cents per page to copy medical records. We will notify you by phone or email in advance of the total charge to retrieve your records. You may pay the fee by credit card or check. Records will not be released until paid in full.

DATE(S) OF INFORMATION TO BE DISCLOSED: From __________ to _________.
(month/year) (month/year)

If left blank, information from the past two (2) years will be disclosed.

Put a CHECKMARK next to the specific documents that apply to your request:

	Intake Note
	Last Clinical Progress Note
	Clinical Progress Notes
	Laboratory Reports
	Consents for Release of Information
	All Medical Records

Put a CHECKMARK next to how you would like to receive your request:

	Mail to the address listed above
	Receive electronically to the email listed above
	Fax to the fax number listed above
	Pick up in person at Baywell Psychiatry Group office

Baywell
Psychiatry Group

Administrative Office
582 Market Street, Suite 812
San Francisco, CA 94104
Tel 415-922-9122
Fax 415-920-9925
www.baywellpsych.com

Put a CHECKMARK next to the purpose that applies to your request:

	Care Coordination
	Insurance Eligibility/Benefits
	Legal Investigation
	Obtain Collateral Information
	Personal (at my request)
	Other:

EXPIRATION OF AUTHORIZATION:
Unless otherwise revoked, this authorization will expire on the following date, event of condition:_________________________. If no date is indicated, this authorization will expire automatically in ninety (90) days from the date of signature.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the medical records department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures; (a) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/ policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

I have read and understand the information in this Authorization form.

Signature of Patient or Legal Guardian:	Date:
Printed Name:	

FOR OFFICE USE ONLY:

Processed Date:
Processed By: