Chambers Health *What You Need - Where You Are*

Chambers County Public Hospital District #1
d/b/a Bayside Community Hospital
Bayside Clinic, West Chambers Medical Center, The Wellness Center
Authorization for Disclosure of Protected Health Information

Patient Name	Date of Birth	SS#	MR#

____ ____________________
Address Telephone #

I hereby authorize Bayside Community Hospital to release the information from the medical records of:

____________________________________ For treatment date(s) ____________________
Patient Name Specify date

To: ____
Name/Address of Person/Organization to which disclosure is to be made

Fax# ____________________________ Phone# ____________________________

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Other (explain below)

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Select Below

☐ Abstract/Pertinent Information
☐ Lab
☐ Emergency Room Record
☐ Imaging/Radiology
☐ Nursing Notes
☐ History & Physical
☐ Cardiac Studies
☐ MD Progress Notes
☐ MD Orders
☐ Face Sheet
☐ Operative/Procedure Report
☐ Physical Therapy Notes
☐ Other: ____________________________________

☐ Entire Record EXCLUDING HIV Testing & Chemical Dependency

☐ Entire Record INCLUDING HIV Testing & Chemical Dependency

☐ Entire Record INCLUDING – HIV Testing Only

☐ Entire Record INCLUDING – Chemical Dependency Only

☐ Itemized Bill

This authorization expires 180 days from the date signed below and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of Bayside Community Hospital, Bayside Clinic and/or West Chambers Medical Clinic or The Wellness Center at Bayside to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

____________________ ____ ____________________
Date Signature of Patient/Parent/Conservator/Guardian Authority/Relationship to Patient