Chambers County Public Hospital District #1
d/b/a Bayside Community Hospital
Bayside Clinic, West Chambers Medical Clinic
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:

_____ (Patient Name) For treatment date(s) _____ (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)

_____

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

□ 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
□ Other: _____

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 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 _____

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.

Released by: _____
Date: _____