Bayside OB/GYN Inc.,
235 Plain St. Suite 401
Providence, RI 02905
401-421-1710

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME (please print)

Name: _____Maiden Name: _____

Current Address: _____

Date of Birth: _____ Telephone Number: _____

RELEASE RECORDS FROM

Physician Name: _____

Address: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

RELEASE RECORDS TO

Physician Name: _____

Address: _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

WHAT IS BEING RELEASED

_____ All records
_____ Records from _____/_____/_____ to _____/_____/_____
_____ Only those specific records described as follows:
_____
_____

DO NOT SEND _____HIV Records _____Psychological Records
_____Sexually Transmitted Disease Records
_____Drug and Alcohol Abuse Records

FOR THE PURPOSE OF ____Insurance ____ Second Opinion ___Moving
____ Continuity of Care
____Other_____
_____

By signing below I also release **Bayside OB-GYN, Inc**. from any and all responsibility that may arise from this authorization. I may withdraw this authorization at any time with written notification to **Bayside OB-GYN, Inc.,** provided that you do so in writing and to the extent that we have already disclosed the information in reliance to this authorization.

This authorization expires on _____/_____/_____ (optional) If no expiration date is given, then this authorization shall remain in effect for 180 days.

_____

Patient Signature (Parent/Guardian's signature if a minor) Date

_____

Witness Signature Date

***We cannot release records from other Doctors.
This entire form must be filled out correctly in order to have an invoice generated for medical records.Medical record release fees: $15.00 Base Fee plus $.25 cents per page for the first 100 pages, and $ .10 cents per page after 100. A Special Handling charge of $10.00 will be added if needed within 48 hours. A retrieval fee of $10.00 must be paid in advance if chart is in storage. Please allow 3-4 weeks to process your request once invoice is paid.