



Bay Area Orthopedic Surgery and Sports Medicine
 100 Hospital Dr. Suite 303
 Vallejo, CA 94589
 Phone 707-645-7210 Fax 707-645-7249
 www.baosurgery.com
 administrator@baosurgery.com

Incoming - Authorization for Release of Information

PATIENT NAME _____
LAST, FIRST

DATE OF BIRTH: _____ SS#: _____

ADDRESS: _____

HOME PHONE: _____ ALTERNATE PHONE: _____

INFORMATION REQUESTED FROM

FACILITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:	FROM	DATES	TO
History and physical exam	FROM _____	TO _____	_____
Progress notes	FROM _____	TO _____	_____
Lab reports	FROM _____	TO _____	_____
X-ray reports	FROM _____	TO _____	_____
Other: _____	FROM _____	TO _____	_____

I specifically authorize the release of information relating to:

- Substance abuse (including alcohol/drug abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

 SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE:

- Changing physicians Consultation/second opinion Continuing care
- Legal School Insurance Workers Compensation
- Other (please specify): _____

1. I understand that this authorization will expire 90 days after I have signed the form.



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- 2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
- 3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- 4. I understand that if I am being requested to release this information by my physician for the purpose of: _____
 - a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
 - b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN/
AUTHORIZED PERSON

DATE

RELATIONSHIP TO PATIENT

Office Use Only

Date Records Received: _____

By: _____