BABY STEPS DAYTONA

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REQUEST FOR RELEASE OF MEDICAL INFORMATION

Patient Name_____
Address:_____
Phone:_____ Date of Birth:_____/_____/_____ SS#:_____

The purpose for release of information at the request of the individual is.
_____Insurance _____Legal Action _____Continuing Care Other (specify)_____
Date Information Needed:_____/_____/_____ Mail_____ Pick Up_____ Fax#:_____

I hereby authorize Baby Steps Daytona to use and disclose to ( ) or obtain from ( ):
Physician's Name:_____
Address:_____
Phone:_____ Fax #:_____

The following information contained in my medical record regarding my hospitalization, care and treatment: Date(s) of Service:_____

___Complete Medical Record	___Office Report	___Annual Exam Report
___Mammogram Report	___Bone Density Report	___U/S Report
___Operative Reports	___Discharge Summary	___Consult Report
___Laboratory Report	___Pathology Report	___Genetic Testing

___Other (please specify)_____

The information used or disclosed pursuant to this authorization:
_____May _____May not include information related to HIV/AIDS.
_____May _____May not include information related to mental health.
_____May _____May not include information related to substance abuse or alcoholism.

Important Notice: You have the right to revoke this authorization. Your revocation must be in writing and addressed to: Baby Steps Daytona, 421 S Keech St, Daytona Beach, FL 32114. This revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary and the provision of health care services is not conditional on whether I sign this authorization. The information used or disclosed pursuant to this authorization may be disclosed by the recipient of the information and may no longer be protected by applicable law or regulations. I understand I have a right to a copy of this signed authorization.

_____ _____
Patient's Signature Date

_____ _____
Approved by Provider Person Sending Records