Bayshore Urgent Care
A Smart ER Alternative

308 53rd Ave E
BRADENTON FL 34203
PHONE: 941-900-7900
FAX: 941-538-5015

AUTHORIZATION FOR RELEASE OF RECORDS

I HEREBY AUTHORIZE THE USE OF DISCLOSURE OF MY INDVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.
I UNDERSTAND THAT IF THE ORGANZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

PATIENT NAME: _____ **DATE OF BIRTH: _____**

I HEREBY AUTHORIZE BAYSHORE URGENT CARE TO SEND RECORDS TO THE FOLLOWING DOCTOR, OFFICE, OR INSTITUTION.

TO RELEASE A COPY OF MY PROTECTED HEALTH INFORMATION TO THE DOCTOR, OFFICE, OR INSTITUTION LISTED ABOVE.

SPECIFIC DESCRIPTION OF INFORMATION REQUESTED:

__ ALL MEDICAL RECORDS __ MRI FILMS __ X-RAY REPORTS ___ CT REPORTS

___EMERGENCY ROOM RECORDS ___HOSPITAL INPATIENT RECORDS ___ PHYSICAL THERAPY RECORDS

OTHER: _____
DATE OF SERVICE:
FROM: _____ TO: _____

- THE PATIENT MUST READY AND INITIAL THE FOLLOWING STATEMENT:

I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS FORM AFTER I SIGN.
PT INITIALS: _____

- THE PATIENT OR PATIENT'S REPRESENTATIVE MUST READ AND INITIAL THE FOLLOWING STATEMENTS.
  1. I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE ON ____/____/_____.
     PT INITIALS: _____
  2. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE PRACTICE IN WRITING. BUT IF I DO IT WONT HAVE ANY EFFECT ON ANY ACTIONS THAT TOOK PLACE BEFORE THEY RECEIVED THE REVOCATION.
     PT INITIALS: _____

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESNTATIVE **DATE**
(FORM MUST BE COMPLETED BEFORE SIGNING) ***YOU MAY REFUSE TO SIGN THE AUTHORIZATION**