BAY INTERNISTS, INC.
Your center of excellence for patient-focused healthcare

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I, _____

Physical Street: _____ *D/O/B:*_____
City, State, Zip: _____ *SSN:*_____
Home Phone: _____ *Previous Name:* _____

Authorize and request from:

Provider/Hospital: _____
Address: _____
_____
Phone: _____
Fax: _____

Release of:

☐ *Complete medical record*
☐ *Only the following records or types of health information (including any dates)*
_____
_____

To:

Bay Internists, Inc.
Provider:_____
PO Box 1599
107 DMV Drive
Kilmarnock, VA 22482
Phone: (804) 435-3103
Fax: (804) 435-6695

Signature: _____ Date:_____

Relationship if Representative:_____
Witness Signature:_____