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

DR. STEVEN F. GLESSNER
DR. JOHN DESCHAMPS
DR. KEVIN J. MCGRATH
DR. PATRICIA K. MONGE-MEBERG
DR. JUNE B. DAFFEH
JACKIE L. OREN, RN, FNP
SHEILA A. BRANSON, ACNP-BC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____

Date of Birth: _____

Previous Name: _____ Social Security#: _____

I request and authorize *Bay Internists, Inc.* to release the healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

_____

☐ Other:

_____

_____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED