AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I,_____, D/O/B:_____, hereby authorize and request that,

Provider/Hospital: _____

Address: _____

_____

Phone: _____

Fax: _____

Release the following information

☐ Complete medical record

☐ Only the following records or types of health information (including any dates)

_____

_____

To:

Bay Internists, Inc.

Attn: _____

PO Box 1599

107 DMV Drive

Kilmarnock, VA 22482

Phone: (804) 435-3103

Fax: (804) 435-6695

_____

Date

_____

Signature

Physical Address: _____

_____

*Home Phone:*_____

_____

Relationship if Representative

_____

Witness