

Medical Records Release Purpose: Use and Disclosure for TRANSFER or CONTINUED CARE

Patient's Name			Please	Please Print		
disclosu Account this prac	re by the ability Ac tice. In fa	recipient and to to (HIPAA) Privact, I have the		d by the Federal Health I sign this authorization in		
	TO FROM Bayside Family & Sports Medicine 2325 Summit Park Dr Suite 3 Petoskey Phone: 231.439.5100 Fax: 231.439					
	TO FROM Provider Facilit		y			
	Address					
		Telephone			Fax	
New	Patier	nts: We ask	c your former medica	I facility to provide	the following 12 items	
		Medical Rec		□ All Colonoscop	☐ All Colonoscopy w/ Pathology	
Last 2 years of service at your facility				☐ EKG / EMG / EEG Report		
□ All Cardiovascular Testing				☐ Operative Report		
☐ Laboratory Studies - Last 2 years ONLY				☐ Emergency / Urgent Care Report		
□ Current Medication List				☐ Mammography		
☐ X-ray / Radiology / Bone Density				Past 2 mammograms & any abnormal results		
☐ Immunizations				☐ Other		
	All Path	ology Record	ls (Including Paps)			
I must o	heck or SED. I	ne or more of understand if	e requested medical information the following types of he I do NOT check any of the Recipient may include	ealth information which he 3 following items, the	I DO NOT WISH	
	Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse					
	Records of HTLV-III or HIV testing (AIDS test) result, diagnosis and/or treatment					
	Psychiatric, psychological records for mental, physical and/or emotional illness including narrative summary, test, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.					
upon this Sports M	s authori ledicine.	zation. My writ This informati	uthorization in writing exce ten revocation must be sub on may not be used for any s release is effective for on	omitted to the Privacy Off y other purpose or releas	icer at: Bayside Family & ed to any other person(s)	

Date

Signature of Patient or Legal Guardian