Bay Area Chest Physicians

HIPAA Release Form

Name: _____ Date of Birth: ___/___/___

Today's Date: ___/___/___

Release of Information

- ☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:
- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____
- ☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorizes Bay Area Chest Physicians to review my external prescription history.

By signing this consent form you are agreeing that your provider at Bay Area Chest Physicians may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Print Patient Name: _____ Date of Birth: ___/___/___

Signature of Patient or Guardian: _____
Date Signed: ___/___/___

Relationship to Patient: _____