BAY AREA MOBILE
CLINIC

Junise Belizaire, ARNP, FNP-C

5450 Bruce B Downs Blvd | Wesley Chapel, Fl 33544 USA
Phone: 813-924-8911 | Fax: 484-971-7682 | bayareamobileclinic@gmail.com |
www.bayareamobileclinic.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, Bay Area Mobile Clinic (BAMC) will be unable to comply with the request. Bay Area Mobile Clinic may not condition treatment, payment, enrollment or eligibility on signing the authorization. BAMC may disclose the information that you put on the form as permitted by law.

Patient's Name: Date of Birth:

Previous Name: Last four of Social Security #:

I request and authorize Bay Area Mobile Clinic to release the information specified below to

Name of Person/Organization:

Address:

Phone:

Fax:

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

◉ All healthcare information ○ Other

I understand that the information to be released includes information regarding the following condition(s):

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt to Bay Area Medical Clinic. Without my express revocation, the authorization will automatically expire in 90 days. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

Patient Signature: _____ Date signed: _____