Baymeadows Primary Care, Inc

Authorization for Release of Medical Records **to:**

Baymeadows Primary Care, Inc
10058 Baymeadows Rd
Jacksonville, Fl 32256
Ph: 904-636-5400 Fax: 904-928-0654

PATIENT INFORMATION (Please Print):

Name ______________________________ DOB: ____________

Social Security Number ________________

I, the undersigned, hereby authorize

____
Name of Person, Institution or Agency

____
Complete Mailing Address

____
City State ZIP
Ph #: ____________________ Fax # ____________________

to release medical information concerning the above named patient to Baymeadows Primary Care, Inc. This medical evaluation will contain copies of discharge summary letters or clinical notes pertaining to the patient's evaluation and treatment.

____
Print Patient Name:

____ ________________
Signature of Patient or Legal Guardian Date:

____
Address City State ZIP

____
Phone/ Cell #

____
Relationship, if Not the Patient Witness

Form Mailed/Faxed: ____________

Practice Employee Signature: ______________

10058 Baymeadows Road, Jacksonville, FL 32256 Phone: (904) 636-5400 Fax: (904) 928-0654

BPC 019.08-Medical Records Receiving records Form

120552 Rec Release To (03.01.12) TO REORDER CALL INHEALTH RECORD SYSTEMS 800-477-7374