Authorization for Release of Medical Information and Protected Health Information

Name: _____ DOB: _____
Last First Middle

Your e-mail: _____ Your Phone # _____

I, hearby authorize:

Facility Name _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To disclose my medical information to:

A Division of BASS Medical Group
112 La Casa Via Suite #300 Walnut Creek, CA 94598
Phone: 925-239-0012 Fax: 925-239-0011

Information to be disclosed:

This authorization permits the above named health care provider to receive the following medical records:

☐ All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes, billing information, correspondence, and records from my other healthcare providers that the above-named health care provider may hold.

☐ All my healthcare information described above *except* for the following:

_____

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

Patient Signature: _____ Date: _____