HIPAA Disclosure & Authorization Form

Clinic: Bay Point Healthcare, LLC	**Doctor: Bruce A. Woodford, DO**	**Date:**
Patient Name: (Last,First,M.I.):		**DOB**:

Listed Address:	**Preferred Correspondence Address:**
Listed Phone Number:	**Preferred Phone Number:**
Listed Email Address:	**Preferred Email Address:**
Would you like our correspondence with you to be marked as "Confidential"? ☐ Yes ☐ No	**May we identify ourselves over the phone?** ☐ Yes ☐ No **May we leave messages?** ☐ Yes ☐ No

Authorization to Release Information

I, ___________________________________, hereby authorize the doctor and/or clinic listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Family Members:		
Name	*DOB*	*Relationship*

I further release my medical information to the following physicians, clinics, and/or hospitals::

Medical Professionals:		
Doctor	*Clinic*	*Phone*

Name of Patient | **Name of Guardian or Personal Representative/Responsible Party**

Signature of Patient | **Signature of Guardian or Personal Representative/Responsible Party**

Date | **Date**