BW PRIMARY CARE
Bridge to Wellness

LIFEBRIDGE HEALTH

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Records to be released FROM:_____
Business Name:_____
Address:_____
City, State, Zip:_____
Telephone:_____ **Fax:**_____

I Hereby request and authorize you to furnish records for the purpose of **continuity/continuing care** or at my request. Release is from the **last two years** to **present**. Please include Labs, Radiology, Immunizations or ALL.
(Please circle selection)

Records to be SENT to: BW Primary Care LLC
Address: 6190 Georgetown Blvd
City, State, Zip: Eldersburg, MD 21784
Telephone: 410-552-5050 Fax: 410-552-0200

Patient Name: _____ **DOB:** _____
Address: _____ **City, State, Zip:** _____
Phone Number: _____ **SSN:** _____

I understand the following:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it.
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations.
3. I am entitled to a copy of this document.
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment or eligibility for benefits.
5. There may be a charge for the release of these records pursuant to 45 CFR 164.524 ⓒ (4) (HIPAA)
6. This authorization shall expire upon written request to revoke or according to state law.
7. A copy of this authorization is as valid as the original.

_____ Date: _____
Signature of Patient or Patient Representative

Medical Records Coordinator at BW Primary Care, LLC.
Description of Representative's Authority to Act for Patient