MAGIC CITY Wellness Center
A BAO Affiliated Program

Medical Records Release Form

Patient Name: _____ **DOB:** _____

Patient Phone: _____

Information Requested:

☐ All Medical Records

☐ Specific Information: _____

Send Information To:

Name: _____

Send by: ☐ Mail ☐ Fax ☐ Email

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Email: _____

I _____ (Name), hereby grant permission to release confidential health information regarding above named patient to the named entity above. I understand that my records are currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I further understand that the information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law.

_____
Printed Patient / Guardian Name

_____
Signature

_____
Date

Clinic Use ONLY:
Chart #: