BAY ANESTHESIA
GROUP
THE CARE YOU NEED, WHERE YOU NEED IT

Authorization for Release of Medical Information

Authorization

I hereby authorize the release of all health information pertaining to medical history, mental or physical condition and treatment received, to Bay Anesthesia Group. This information is imperative in order to be effectively screened by my anesthesiologist for dental treatment under General Anesthesia.

I also hereby authorize the release of any health information received by my anesthesiologist to be shared with the treating provider of my dental services, should it pertain to my safety and well being while under General Anesthesia.

My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

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Patient Signature or Responsible Party Date

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Responsible Party Relationship to Patient

160 W. Foothill Pkwy Ste 105 #244 · Corona, CA 92882