Maria D. Francis, MD
Old Fort Bay Pediatrics

Old Fort Bay Town Centre · P. O. Box SS-19633 · Nassau, The Bahamas
Tel: (242) 377-7050/51 Fax: (242) 377-7052

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified upon request to the address specified at the time of the request.

Provider:	Patient: DOB:

RECORDS AUTHORIZED TO BE RELEASED:

- □ Admission history and physical
- □ Discharge summary
- □ Complete hospital chart
- □ Office notes
- □ Outpatient records
- □ Psychiatric and other mental health records
- □ Records relating to drug or alcohol abuse (must specify the extent or nature of the records to be released)
- □ Medication administration logs, dietary logs, staff contact or service logs, and other records that may not be part of my individual medical record, but which contain information relating to me. (These records should be redacted to protect information pertaining to other patients.)
- □ Other (specify): _____

Extent or nature of records to be released:
(example, specific hospitalization or visit)

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the health care provider but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

_____

Patient or Representative Date

_____

Name of Representative (print)

_____

Relationship to Patient