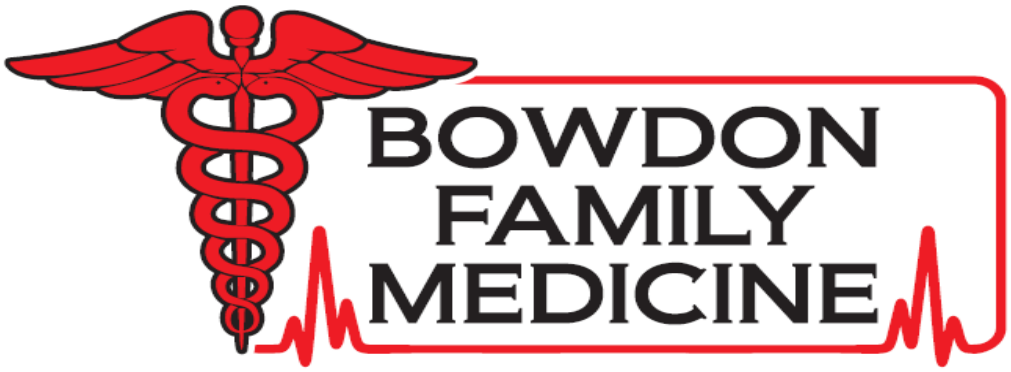

REQUEST AND AUTHORIZATION TO DISCLOSE AND/OR COPY MEDICAL INFORMATION (PROTECTED HEALTH INFORMATION)

Medical Record Number_____ **Account Number**_____

I, _____

(Patient or legal representative name and address)

Do hereby authorize BFM LLC. to disclose information or copies thereof covered under privacy regulations issued pursuant to the HIPPA ACT of 1996 to:

_____

(Person or organization to whom the medical record information is to be released)

from Medical Records maintained by BFM LLC. Pertaining to the care and treatment of:

(Patient Name)_____

Care and treatment rendered from (Date) _____through (Date)_____

This consent and authorization includes, for the period indicated, the care and treatment records designated pertaining to the patient for physical and/or emotional illness including psychological or psychiatric treatment and/or alcohol and drug abuse, and/or AIDS (HIV) related testing or illness, and/or testing for sexually transmitted diseases. The nature and extent of the information to be released is:

	Patient ID Card		**Operative Report**		**Imaging Reports**		**Image Film**
	Abstract only		**Clinical Notes**		**Laboratory Reports**		**Film Category**
	ED Report		**Physician Orders/Notes**		**EKG:EMG Report**		
	History/Physical		**Physical Therapy Notes**		**Cardiac Cath Video**		
	Discharge Summary		**Respiratory Therapy Notes**		**Other**		**Complete Record**

The requested use or disclosure of this medical information is:

I Hereby acknowledge and understand that this authorization is a waiver of the confidential and privileged nature of the records designated above but only with respect to the specified purpose(s) for which this disclosure is made. I further acknowledge and understand that this authorization will prevent the patient from making claim for a violation of privacy in connection with release of the medical information as described herein. I understand that BFM LLC. Cannot require me to sign tis authorization in order to receive treatment unless the provision of healthcare is solely for the purpose of creating phi for disclosure to a third party (ex: employee physical exam) or for research related treatment, in which BFM LLC. will not provide the service unless I sign this authorization.

This request and authorization may be revoked at any time by written notice received by BFM LLC. Health information management department, but any revocation will not apply to records already furnished in reliance upon this request shall remain valid until revoked, or upon the expiration of sixty (60) days, whichever occurs first.

_____

(Signature of patient or Legal Representative) (Relationship) (Date) (Witness)

_____

(Signature of Minor patient when required) (Date) (Witness)