***Please fax or mail completed form to WFBaker MD and Associates for processing.**

AUTHORIZATION FOR USE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient Name: _____ Date of Birth: _____
Please Print

Other Names Used: _____ Phone #: _____

Patient Address: _____ Social Security #: _____

_____

I AUTHORIZE: **Dignity Health Medical Group Bakersfield**
9300 Stockdale Hwy., Suite 300
Bakersfield, CA 93311

TO DISCLOSE TO: **William F. Baker, Jr., M.D. & Associates**
3008 Sillect Avenue, Suite 240
Bakersfield, CA 93308
Phone: (661) 716-4703
Fax: (661) 885-4867

I hereby request any and all of the following medical records be disclosed:

Initial ____ ☐ **Entire medical record from the most recent (EMR) Electronic Medical Record.**

EXPIRATION: This authorization will automatically expire one (1) year from the date of execution unless a different end date is specified:_____
(Insert date if needed)

Signature: _____ **Date:** _____

_____ _____
Print name of personal representative if signed by other than patient Relationship to Patient

_____
Witness Signature