



Patient Release of Information

Patient Name: _____

Date of Birth (DOB): _____ Phone Number: _____

I, the undersigned, hereby authorize the release of my or my child's medical records to:

Bay Area Clarity- Megan DeShazo, MD

Fax: (251) 999-0102 (Preferred Method)

Email: forms@bayclarity.com Phone : (251) 999-0102

Mail: 25369 US-98 E, Suite D2, Daphne, AL 36526

I would like to obtain notes from visits pertaining to mental health, including ADHD and any associated screenings, as well as my or my child's last Well Child Visit from the following clinic or provider:

Clinic or Provider Name: _____

Clinic Phone: _____

Clinic Address: _____

Clinic Fax: _____

I give permission for my or my child's medical records to be sent to Bay Area Clarity.

Signature: _____ Date: _____

Relationship to Patient: _____