MRN: ______________________

PATIENT HEALTH INFORMATION IDENTITY VERIFICATION FORM

1. Patient Information

First Name | Middle Initial | Last Name (list Previous Last Name if applicable)

Address | City | State | Zip Code

Date of Birth | Phone Number | Social Security Number

2. Request that BayCare Clinic Disclose my Health Information to:

☐ Myself

☐ ______________________
Name

3. Delivery Method Requested:

☐ Mail to: ______________________
Address | City | State | Zip Code

☐ Email to: ______________________

4. Format Requested:

☐ My AdvocateAurora/MyBayCare Portal* (Patient Only – No Charge)
*NOTE: BayCare Clinic Oral and Maxillofacial Surgeon records are not available on the portal.
☐ Encrypted email (provide email address in #3)
☐ Paper (fee applies)
☐ CD (fee applies)

5. Information to be Disclosed:

Dates: ______________________

Type: ☐ Billing Records ☐Medical Records

6. Signature of Patient or Representative:

Signature of Patient or Patient Representative | Date | Printed Name / Relationship of Patient Representative

BayCare Clinic will accept any written request from a patient for access to or copies of their own billing/medical records. This form is not required. However, it will provide BayCare Clinic with all needed information to ensure an accurate response.

Form 80020
Rev 1/2021