Baptist Facility Who is Releasing Information	
❑ **Baptist Medical Center Jacksonville/Wolfson Children's Hospital** 800 Prudential Drive, Jacksonville, FL 32207 Attn: HIM Phone: (904) 202-1169 Fax: (904) 202-2233	❑ **Baptist Medical Center South** 14550 St. Augustine Road, Jacksonville, FL 32258 Attn: HIM Phone: (904) 271-6040 Fax: (904) 271-6044
❑ **Baptist Medical Center Beaches** 1350 13th Avenue South, Jacksonville Beach, FL 32250 Attn: HIM Phone: (904) 627-2945 Fax: (904) 627-1824	❑ **Baptist Medical Center Nassau** 1250 South 18th Street, Fernandina Beach, FL 32034 Attn: HIM Phone: (904) 321-3602 Fax: (904) 321-3615
❑ **Other Facility:** Orange Park Pediatrics- Baptist Primary Care	**Fax Number:** 904-269-3018
Address: 2140 Smith Street	**City, State, Zip Code:** Orange Park, FL 32073

I hereby authorize the above-referenced entity to release the medical information about me indicated below to the following recipient:

To Whom Information Will Be Provided	
Entity/Individual:	**Address:**
City, State, Zip Code:	**Fax Number:**
Email Address:	**Telephone Number:**

☐ ***Send Records via Unencrypted Email.*** *Please be advised that unencrypted communications are not secure and there is some level of risk that a third party could see or intercept your Protected Health Information (PHI) without your consent when receiving unencrypted electronic media or email. We are not responsible for any unauthorized access to your PHI or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in unencrypted electronic format or email. By choosing delivery by unencrypted email, you acknowledge that you understand the risks explained above.*

☐ ***Send Records to My Baptist Chart***

Patient Name:	**Birth Date:**	**Medical Record Number:**
Address: **City:** **State:** **Zip:**		**Telephone Number:**

Records Being Released:

❑ Abstract *(all asterisked items)*	❑ Emergency Department Records*	❑ Cardiovascular Reports*	❑ Current Medications*
❑ History & Physical/Intake*	❑ Laboratory Results*	❑ Operative/Procedure Reports*	❑ Psychological Reports
❑ Consultation Records*	❑ Radiology Reports* *(no images)*	❑ Immunizations/Allergies*	❑ Progress/Office Notes
❑ Discharge/Clinical Summary*	❑ Pathology Reports*	❑ Other: _____	

Images Needed:

❑ Radiology Images	❑ Ultrasound (Sonogram) Images	❑ CT Scan Images
❑ Magnetic Resonance Imaging (MRI) Images	❑ Nuclear Medicine Images	❑ Other: _____

Dates of Service Needed:

❑ Last Visit Only ❑ From: _____ To: _____

Purpose of Release:

❑ Continued Care*	❑ Personal	❑ Disability
❑ Research	❑ Insurance	❑ Department of Children's & Family Services (DCFS)
❑ Legal (Attorney)	❑ Other: _____	

* If for continued care, records needed for doctor's appointment on _____ (date) at _____ (time).

I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Baptist Health or the above-referenced entity(s) will not depend in any way on whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.

I understand that state and federal law may prohibit the Recipient from re-disclosing information provided pursuant to this Authorization, but that neither Baptist Health nor the above-referenced entity(s) has any control over the Recipient and cannot, therefore, guarantee that the Recipient will not re-disclose such information. I hereby release Baptist Health and the above-referenced entity(s) from any and all liability related to (i) their reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

Signature of Patient _____ Date _____ Time _____

If the patient is (i) a minor, the patient's parent or guardian should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

Signature of Representative _____ Date _____ Time _____ Telephone Number _____

Name of Representative _____ Relationship to Patient _____

This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written authorization of the individual to whom it pertains, their authorization representative, or as otherwise permitted by law. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

BAPTIST HEALTH

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND RADIOLOGY IMAGES

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PATIENT LABEL