



Depend On Us For Life.SM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

check one

- BAPTIST MEDICAL CENTER 800 Prudential Drive, Jacksonville, FL 32207
Attn: Medical Records Fax: (904)202-2233
- BAPTIST MEDICAL CENTER *BEACHES* 1350 13th Avenue South, Jacksonville Beach, FL 32250
Attn: Medical Records Fax: (904)247-2963
- BAPTIST MEDICAL CENTER *NASSAU* 1250 South 18th Street, Fernandina Beach, FL 32034
Attn: Medical Records Fax: (904)321-3615
- BAPTIST HOME HEALTH CARE 3563 Philips Hwy, Suite 202, Jacksonville, FL 32207
Attn: Medical Records Fax: (904)202-4373
- PAVILION INFUSION THERAPY 3563 Philips Hwy, Suite 202, Jacksonville, FL 32207
Attn: Medical Records Fax: (904)398-2225
- WOLFSON CHILDREN'S HOSPITAL 800 Prudential Drive, Jacksonville, FL 32207
Attn: Medical Records Fax: (904)202-2233

Patient Name:		Birth Date:
Social Security No.:	Medical Record (MMI) No.:	
Address:		Telephone No.:

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

Recipient Name:		Telephone No.:
Address:		Fax No.:
Documents Needed:	<input type="checkbox"/> EKG Reports <i>(no films)</i>	<input type="checkbox"/> Cardiovascular Reports
<input type="checkbox"/> Entire Record <i>(no films)</i>	<input type="checkbox"/> Radiology Reports <i>(no films)</i>	<input type="checkbox"/> Operative / Procedure Reports
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Anesthesia Records	<input type="checkbox"/> Mammography Reports <i>(no films)</i>
<input type="checkbox"/> Emergency Department Records	<input type="checkbox"/> Consultation Records	<input type="checkbox"/> Other: _____
Dates of Service Needed:	<input type="checkbox"/> From: ___/___/___ To: ___/___/___	
<input type="checkbox"/> All	<input type="checkbox"/> Last Visit Only	
Purpose of Release:	<input type="checkbox"/> Research	<input type="checkbox"/> Insurance
<input type="checkbox"/> Continued Care *	<input type="checkbox"/> Disability	<input type="checkbox"/> Personal
<input type="checkbox"/> Legal (Attorney)	<input type="checkbox"/> Dept. Children's & Family Services (DCFS)	<input type="checkbox"/> 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 transmissible 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 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 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 from any and all liability related to (i) their reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

I understand that the above-referenced entity may charge me reasonable, cost-based fees for such records of up to \$1.00 per page for paper records (up to \$2.00 per page for non-paper records) and an administrative fee of \$1.00 for each year of records requested. The above-referenced entity will waive such fee for copies provided to another healthcare provider for continuing care.

By signing below, I authorize the entity checked above to release medical information about me as described above.

Signature of Patient

Date

If the patient is (i) a minor, the patient's parent 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

Telephone

Name of Representative

Relationship to Patient



101903