



check where treated

- BEACHES      1141 Beach Blvd., Jacksonville Beach, FL 32250  
Attn: Medical Records    Fax: (904)249-0042
- SAN MARCO      1325 San Marco Blvd., Suite 301, Jacksonville, FL 32207  
Attn: Medical Records    Fax: (904)202-2191
- WESTSIDE      5805-1 Ramona Blvd., Jacksonville, FL 32205  
Attn: Medical Records    Fax: (904)693-0751

**BAPTIST OCCUPATIONAL HEALTH**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

<b>Patient Name:</b>		<b>Birth Date:</b>
<b>Social Security No.:</b>	<b>Medical Record (MMD) No.:</b>	
<b>Address:</b>		<b>Telephone No.:</b>

I hereby authorize Baptist Occupational Health and its representatives to release the medical information about me indicated below to the following recipient:

<b>Recipient Name:</b>		<b>Telephone No.:</b>
<b>Address:</b>		<b>Fax No.:</b>
<b>Documents Needed:</b>		
<input type="checkbox"/> Entire Record	<input type="checkbox"/> Treatment Summary Only	<input type="checkbox"/> Other: _____
<b>Dates of Service Needed:</b>		
<input type="checkbox"/> All	<input type="checkbox"/> Last Visit Only	<input type="checkbox"/> From: ___/___/___ To: ___/___/___
<b>Purpose of Release:</b>		
<input type="checkbox"/> Continued Care	<input type="checkbox"/> Research	<input type="checkbox"/> Insurance
<input type="checkbox"/> Legal (Attorney)	<input type="checkbox"/> Disability	<input type="checkbox"/> Personal
	<input type="checkbox"/> Dept. Children's & Family Services (DCFS)	<input type="checkbox"/> Other: _____

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 services from Baptist Occupational Health 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 Baptist Occupational Health may charge me or the Recipient reasonable, cost-based fees for such records.

I understand that State and federal law may prohibit the Recipient from re-disclosing information provided pursuant to this Authorization, but that Baptist Occupational Health has no control over the Recipient and cannot, therefore, guarantee that the Recipient will not re-disclose such information. I hereby release Baptist Occupational Health from any and all liability related to (i) its reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

By signing below, I authorize Baptist Occupational Health and its representatives to release medical information about me as described above.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Name of Representative

\_\_\_\_\_  
Relationship to Patient

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