

- BAPTIST MEDICAL CENTER DOWNTOWN 800 Prudential Drive, Jacksonville, FL 32207
Attn: HIM Fax: (904) 202-2233
- BAPTIST MEDICAL CENTER BEACHES 1350 13th Avenue South, Jacksonville Beach, FL 32250
Attn: HIM Fax: (904) 627-1824
- BAPTIST MEDICAL CENTER SOUTH 14550 St. Augustine Road, Jacksonville, FL 32258
Attn: HIM Fax: (904) 271-6044
- BAPTIST MEDICAL CENTER NASSAU 1250 South 18th Street, Fernandina Beach, FL 32034
Attn: HIM 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) 398-2325
- WOLFSON CHILDREN'S HOSPITAL 800 Prudential Drive, Jacksonville, FL 32207
Attn: HIM Fax: (904) 202-2233

_____ PHONE: _____
 ADDRESS: _____ FAX: _____
 (HOSPITAL / OTHER BAPTIST HEALTH PROVIDER / PHYSICIAN)

Patient Name:			Birth Date:		
Social Security No.:			Medical Record (MMI) No.:		
Address:	City:	State:	Zip:	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:	City:	State:	Zip:	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"/> All		<input type="checkbox"/> Last Visit Only		<input type="checkbox"/> From: ___/___/___ To: ___/___/___	
Purpose of Release:					
<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: _____	
* 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 searching, preparing, copying, mailing and otherwise producing records. The above-referenced entity will waive some or all of such fees 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 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

Name of Representative Relationship to Patient



AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION



PATIENT LABEL