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:**	**Fax Number:**
Address:	**City, State, Zip Code:**

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:**	**Telephone Number:**

Patient Name:	**Birth Date:**	**Medical Record Number:**

Address:	**City:**	**State:**	**Zip:**	**Telephone Number:**

PORTAL ENROLLMENT: Would you like to be enrolled in the My Baptist Connect patient portal?
❑ Yes ❑ Decline ❑ Previously Enrolled EMAIL ADDRESS: _____

Records Being Released:

❑ Entire Record *(no films)*	❑ Emergency Department Records	❑ Cardiovascular Reports
❑ History & Physical	❑ Laboratory Results	❑ Operative Reports
❑ Consultation Records	❑ Radiology Reports *(no films)*	❑ Anesthesia Records
❑ Discharge Summary	❑ Pathology Reports	❑ Other: _____

Dates of Service Needed:
❑ All ❑ 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.

I understand that the above-referenced entity(s) may charge me reasonable, cost-based fees for searching, preparing, copying, mailing and otherwise producing records. The above-referenced entity(s) will waive some or all such fees for copies provided to another healthcare provider for continued care.

By signing below, I authorize the above-referenced entity(s) 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 Number _____

Name of Representative _____ Relationship to Patient _____

BAPTIST HEALTH

Baptist Medical Center Jacksonville, Jacksonville, FL
Baptist Medical Center Beaches, Jacksonville Beach, FL
Baptist Medical Center Nassau, Fernandina Beach, FL
Baptist Medical Center South, Jacksonville, FL
Baptist Emergency Center Clay, Fleming Island, FL
Baptist Emergency Town Center, Jacksonville, FL
Baptist North Emergency Center, Jacksonville, FL
Wolfson Children's Hospital, Jacksonville, FL

BMC-10044 Rev. 09/16

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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PATIENT LABEL