

# BAPTIST HEALTH SOUTH FLORIDA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

1. I hereby authorize the use and/or disclosure of the below named individual's health information as described below:

Patient Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ Last 4 digits of SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. The health information described below may be used by or disclosed to the following (Select Self or Name of Person/Organization):

|  |   |
|--|---|
| <input type="checkbox"/> <b>SELF:</b><br><b>Format Requested:</b> <input type="checkbox"/> Paper <input type="checkbox"/> E-mail <input type="checkbox"/> USB <input type="checkbox"/> CD <input type="checkbox"/> Other: _____<br><b>Delivery Method:</b> <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Pick-Up<br>Email Address: _____<br>Delivery Address: _____<br>Phone: _____ Fax (if faxing): _____ | <input type="checkbox"/> <b>Name of person/organization:</b> _____<br><b>Format Requested:</b> <input type="checkbox"/> Paper <input type="checkbox"/> E-mail <input type="checkbox"/> USB <input type="checkbox"/> CD <input type="checkbox"/> Other: _____<br><b>Delivery Method:</b> <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Pick-Up<br>Email Address: _____<br>Delivery Address: _____<br>Phone: _____ Fax (if faxing): _____ |
|--|---|

I hereby authorize the following individual(s) or organization(s) to make the disclosure of health information in the manner described herein:

- |   |   |
|---|---|
| <u>Hospitals:</u><br><input type="checkbox"/> Baptist<br><input type="checkbox"/> Bethesda East<br><input type="checkbox"/> Bethesda West<br><input type="checkbox"/> Boca Raton Regional<br><input type="checkbox"/> Doctors<br><input type="checkbox"/> Doral<br><input type="checkbox"/> Fishermen's<br><input type="checkbox"/> Homestead<br><input type="checkbox"/> Mariners<br><input type="checkbox"/> South Miami<br><input type="checkbox"/> West Kendall<br><input type="checkbox"/> Other _____ | <u>Other Facilities/Locations:</u><br><input type="checkbox"/> Ambulatory Surgery Center<br><input type="checkbox"/> Baptist Health Medical Group<br>Specialty _____<br>___Broward ___Monroe ___Miami-Dade ___Palm Beach<br><input type="checkbox"/> Diagnostic Center<br><input type="checkbox"/> Lynn Cancer Institute<br><input type="checkbox"/> Miami Cancer Institute<br><input type="checkbox"/> Miami Cardiac & Vascular Institute<br><input type="checkbox"/> Baptist Sleep Centers<br><input type="checkbox"/> Urgent/Express Care Center<br><input type="checkbox"/> Other _____ |
|---|---|

3. **Approximate date(s) of treatment or event:** \_\_\_\_\_

Check the health information you are authorizing to be used/disclosed:

Include All Sections Below

Other Records

- |   |   |
|---|---|
| <input type="checkbox"/> Admission/History & Physical<br><input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> Emergency Record<br><input type="checkbox"/> Consultations<br><input type="checkbox"/> Operation Record<br><input type="checkbox"/> Laboratory<br><input type="checkbox"/> Pathology Report<br><input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medication List<br><input type="checkbox"/> Physician Orders<br><input type="checkbox"/> Progress Notes<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Radiology Images: <input type="checkbox"/> Email <b>or</b> <input type="checkbox"/> CD<br><input type="checkbox"/> Cath Lab Cine/CD |
|---|---|

\_\_\_\_\_ Initial here for HIV tests and results.

\_\_\_\_\_ Initial here for records relating to our Addiction Treatment and Recovery Center at South Miami Hospital. This form may not be used to authorize the use and disclosure of any other health information. A separate authorization is needed for any other use/disclosure.

4. This request is being made for:  Continuation of Care  Self **or**  Other, e.g., insurance, legal purposes: \_\_\_\_\_

5. **Revocation Authorization Process.** I understand that I have the right to revoke this authorization at any time, and that if I revoke this authorization, I must send a written request to: **Baptist Health South Florida Privacy Office, Privacy@Baptisthealth.net.**

I understand that the revocation will not apply to information that has already been released, to future releases to the extent that Baptist Health South Florida has already acting in reliance on this authorization, and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

6. Authorization will expire one year from the date on which it was signed unless another date or event is specified: \_\_\_\_\_  
**Note:** If you are requesting a release of records please ensure that any expiration date or event allows sufficient time for your records to be prepared and sent to the party identified.

7. I understand that this authorization is voluntary. I understand that once the health information described herein is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal privacy laws; however, under federal and state laws respectively, the recipient may be prohibited from re-disclosing substance abuse and HIV/AIDS information without specific written consent of the person to whom it pertains, or as otherwise permitted by such laws. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

8. \_\_\_\_\_  

|  |                            |             |             |
|--|----------------------------|-------------|-------------|
| <b>Signature of Patient*/Personal Representative</b> | <b>Relation to Patient</b> | <b>Date</b> | <b>Time</b> |
|--|----------------------------|-------------|-------------|

\*The above individual is unable to consent because (check one):  Minor  Incompetent  Other (explain): \_\_\_\_\_

You are entitled to a copy of this authorization after you sign it. and for more information, please visit [baptisthealth.net/medicalrecords](http://baptisthealth.net/medicalrecords)  
**(For internal Use Only) If not processed, this form MUST be sent via interoffice mail to Medical Records for processing.**

**Date Received:** \_\_\_\_\_ **Date Processed:** \_\_\_\_\_ **Comments:** \_\_\_\_\_

**Account #:** \_\_\_\_\_ **MR #:** \_\_\_\_\_ **Processed by (print employee name/department):** \_\_\_\_\_

