Patient Account # (for internal use only):_____

HEALTH INFORMATION MANAGEMENT DEPARTMENT

AUTHORIZATION TO REQUEST MEDICAL RECORDS

I hereby authorize the use or disclosure of my Protected Health Information (PHI) as described below. **Furthermore, I understand that my signature below specifically authorizes the release of health care information relating to testing, diagnosis or treatment for: HIV/AIDS virus, Mental health / Psychiatric Disorders, Sexually Transmitted Disease(s), Drug/Alcohol Abuse/ Treatment, if they are a part of my medical record.** I understand that this authorization is voluntary. Once this information has been disclosed, it may be subject to re-disclosure and no longer be protected by federal privacy regulations.

Patient Name:_____

Previous Name, if applicable:_____

Last 4 digits of SSN:_____ Date of Birth:_____

Email Address:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home or Cell Phone:_____ Work Phone:_____

Please note that a copy of a state or federal issued photo identification is required for processing any release of medical information.

PERSON/ORGANIZATION TO RECEIVE INFORMATION: Please send my health information to the following person/organization:

_____Patient (Check if disclosure of information is to the same person named above)

Name (*Individual or Company*):_____

Telephone Number:_____ Fax Number (continuing patient care only):_____

Address:_____

City:_____ State:_____ Zip Code:_____

MEDIA TYPE: Please select which format you wish for the records to be:

_____Electronic (CD) _____Paper

DELIVERY PREFERENCE: Please select one of the following delivery methods:

_____Mail _____In-person pick up _____Fax (another healthcare provider only)

DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

_____Complete Medical record (without billing records) Date(s) of Service:_____

_____Complete Medical Records (with billing records) Date(s) of Service:_____

_____Partial Medical Record (Please Select Below) Date(s) of Service:_____

INFORMATION REQUESTING:

____Face Sheet	____X-ray List	___Lab Reports
____Medication List	____Medical Images / Reports	___Diagnostic Procedure Report
____Consultation Report	____Fetal Monitors	___Operative Report
____Discharge Report	____Progress Notes	___Emergency Room Record
____Billing Records	____Clinic Notes	___After Care Plan
____Pathology Report		

____Other (Describe):_____

NOTICE: If I request records in electronic format, I understand that the records on the CD or available secured portal will be encrypted to help protect my privacy and the security of my health records that the person(s) receiving these records will be furnished with the manner in which to access those encrypted records. Baptist Health is not responsible for the privacy and security of the electronic records on CD or in an email while in transit to and upon receipt by the intended recipient.

EXPIRATION OF AUTHORIZATION: Unless I request in writing otherwise, I understand that this authorization will expire on _____(insert expiration date, not to exceed six (6) months). If I do not specify an expiration date, this authorization will expire six (6) months from the date on which I signed this authorization.

RIGHT TO REVOKE AUTHORIZATION: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department at the Baptist Health facility in which I received care. I understand that the revocation will not apply to any health information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

RE-DISCLOSURE: I understand that if my health information is disclosed to a party other than a healthcare provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

FEES: I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

REFUSAL TO SIGN: I understand that Baptist Health may not condition the provision of treatment, payment, and enrollment in a health plan, or eligibility for benefits on signing this Authorization, except under the following circumstances: (1) Participating in research projects can be conditioned on my signing an Authorization to use and disclose PHI in the research; (2) Initial determinations; (3) Furnishing healthcare sevices to me at the request of a third party can be conditioned on my signing an authorization for disclosure of the PHI to the third party requesting the treatment.

RELEASE AND WAIVER: If the health information that I have requested Baptist Health to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency, alcohol abuse or treatment of any communicable or infectious disease such as acquired immunodeficiency virus (HIV), Venereal Disease, Tuberculosis or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Baptist Health and each of its facilities and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

_____ _____

Signature of Patient (Or Patient's Representative) Date

_____ _____

Printed Name (or Patient's Representative) Date

_____

Relationship to the Patient (if Representative)

A copy of this completed, signed and dates form will be provided to the patient and / or patient's representative and a copy will be placed in the patient's medical record.

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