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):

☐ ***SELF:***	☐ ***Name of person/organization:*** ____________
Format Requested: ☐ Paper ☐ E-mail ☐ USB ☐ CD ☐ Other:________	**Format Requested:** ☐ Paper ☐ E-mail ☐ USB ☐ CD ☐ Other:________
Delivery Method: ☐ Mail ☐ Fax ☐ E-mail ☐ Pick-Up	**Delivery Method:** ☐ Mail ☐ Fax ☐ E-mail ☐ Pick-Up
Email Address: ____________	Email Address: ____________
Delivery Address: ____________	Delivery Address: ____________
Phone: __________ Fax (if faxing): __________	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:

Hospitals:

- ☐ Baptist
- ☐ Bethesda East
- ☐ Bethesda West
- ☐ Boca Raton Regional
- ☐ Doctors
- ☐ Doral
- ☐ Fishermen's
- ☐ Homestead
- ☐ Mariners
- ☐ South Miami
- ☐ West Kendall
- ☐ Other______________

Other Facilities/Locations:

- ☐ Ambulatory Surgery Center
- ☐ Baptist Health Medical Group
  Specialty ______________________
  __Broward __Monroe __Miami-Dade __Palm Beach
- ☐ Diagnostic Center
- ☐ Lynn Cancer Institute
- ☐ Miami Cancer Institute
- ☐ Miami Cardiac & Vascular Institute
- ☐ Baptist Sleep Centers
- ☐ Urgent/Express Care Center
- ☐ Other __________________

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

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

☐ Include All Sections Below

- ☐ Admission/History & Physical
- ☐ Discharge Summary
- ☐ Emergency Record
- ☐ Consultations
- ☐ Operation Record
- ☐ Laboratory
- ☐ Pathology Report
- ☐ Radiology Reports

Other Records

- ☐ Medication List
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Radiology Images: ☐ Email ***or*** ☐ CD
- ☐ Pathology Slides
- ☐ Cath Lab Cine/CD
- ☐ Other: ______________________

______ 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, 786-596-8850.**
   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. ______________________ ______________________ ____________ ________

Signature of Patient*/Personal Representative **Relation to Patient** **Date** **Time**

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

Account #: ______________ MR #: ______________ Processed by *(print employee name/department)*: ______________________

(For internal Use Only) If not processed, this form MUST be sent via interoffice mail to Medical Records for processing.

You are entitled to a copy of this authorization after you sign it.

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* Fees for medical records will be charged in accordance with applicable State and Federal regulations: (F.S. 395.3025 , F.S. 456.057 , 45 CFR ((§164.524)(c)(4))