BAPTIST HEALTH CARE

___ Atmore Community Hospital
___ Atmore Community Home Health
___ Baptist Hospital
___ Baptist Manor
___ Baptist Medical Park
___ The Andrews Institute
___ Gulf Breeze Hospital
___ Jay Hospital
___ Other:
_____

Revision 20070426

Authorization for Release of Protected Health Information

Patient Name: _____
(Last) **(First)** **(Middle)**

SS#: _____ **Date of Birth:** _____ **Telephone #:** _____ **MR#:**_____

1. I hereby authorize the following person / entity:

_____
(Name of Entity / Individual / Class of Persons)

_____
(Address)

_____
(City / State / Zip)

To release to:

_____
(Name of Entity / Individual / Class of Persons)

_____
(Address)

_____
(City / State / Zip)

2. I authorize the following types of information to be released:
__ General Medical __ HIV/AIDS (May not apply to Labs) __ Substance Abuse __ Psychiatric __ Psychotherapy Notes

3. I authorize the following types of records to be released: (check all that apply)
___ General Abstract (includes Face Sheet, Discharge Summary, History & Physical, Operative Report, Pathology, Consultation Reports)
___ Face Sheet __ Pathology ___ Cardiology Reports __ Other: (please specify below)
___ Discharge Summary __ Consultations __ Radiology Reports
___ History & Physical __ Labs __ Radiology Film _____
___ Operative Report __ ER Record (Type: _____)

4. I authorize the following date(s) of service to be released: _____

5. This information is needed for the following purpose(s):
___ Continued Care __ Insurance Claim __ Other: _____
___ Personal Use __ Legal Purposes

6. 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 Facility Medical Records Department. I understand that the revocation will not apply to 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. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____
_____.
If I fail to specify an expiration date, event, or condition, the authorization will expire within **90 days**.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal or State Privacy Laws. If I have questions about disclosure of my protected health information, I can contact the BHC Privacy Officer at (850) 434-4472. I also understand that obtaining medical information under false pretenses is a Federal and State crime, punishable by up to 10 years in prison.

8. If present, alcohol and drug abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations 42CFR, Part2, prohibit making any further disclosure of records without the specific written authorization of the person to whom it pertains or as otherwise permitted by law.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness