Record Request: Authorization to Use and Disclose Protected Health Information ("PHI")

This authorization shall apply to all of the following entities: Baptist Hospital, Inc., Jay Hospital, Inc., Baptist Medical Group, LLC, Baptist Urgent Care, LLC.

Patient's Name	Date of Birth	Medical Record #
Patient's Address	City	State Zip
Phone #	E-mail Address	

By signing this form, I authorize the release of PHI (i.e., medical records) as follows:

FROM the doctor, office or facility written below :	**TO the facility / person written below :**
	☐ **Check here if same as patient**
Hospital, Clinic, person or organization	Hospital, Clinic, person or organization
Attn:	Attn: **(for Substance Use Disorder records- name of PERSON is required)**
Address	Address
Phone Fax	Phone Fax

The following PHI may be released *(check boxes below)***:**

			I further authorize the release of the following information which may be included in the PHI:
☐ General Abstract (Face Sheet, Discharge, Summary, History/Physical, Operative Note, Consult, Pathology Reports)	☐ Physical/Occupational/ Speech Therapy	☐ Discharge Summary	☐ Behavioral Health
		☐ Medication List	☐ Genetic Testing
☐ History and Physical	☐ Radiology Reports	☐ UB-04/CMS 1500 Claim	☐ HIV/AIDS test result
☐ Consultations	☐ Radiology Images	☐ Itemized Bill	☐ **Substance Use Disorder - Describe how much and what kind of information may be disclosed below:**
☐ Emergency Room Record	☐ Lab/Pathology Reports	☐ Other:	
☐ Operative Report(s)	☐ Immunizations		
☐ Clinic/Office Notes – Physician Name:			

Are there specific dates needed? _____ **Dates**

Purpose of this request?	☐ Insurance Claim ☐ Legal Purposes ☐ At the Request of the Patient ☐ Medical Treatment – Physician Name:_____ ☐ Other:_____
Format of Records?	☐ Pick Up ☐ E-mail ☐ Fax ☐ Disc $6.50 ☐ Paper - *Mailed *If mailing, current postage rates apply
Please mail, email or fax completed form to:	**Baptist Health Care** **Email: BHROI@bhcpns.org** **P.O. Box 17804** **Fax: 850.908.2124** **Pensacola, FL 32522** **Phone: 850.908.7119**

This authorization allows any and all of the providers listed above to use and disclose certain PHI, which includes medical records, as I have directed. **I understand that:**

- My Substance Use Disorder records are protected under federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- I have a right to request a list of disclosures of my medical information, if requested in writing.
- I have a right to revoke this authorization at any time by providing written notice to BHC Request of Information, P.O. Box 17804, Pensacola, FL 32522-17804. I understand that the revocation will not apply to information that has already been released in response to this authorization or if the authorization was obtained as a condition of obtaining insurance coverage where the law provides my insurer with the right to contest a claim under my policy.
- Except for Substance Use Disorder and HIV (AIDS) records, once my PHI is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws.
- I understand that if I refuse to sign this authorization, my treatment, payment, enrollment or eligibility for benefits will not be affected.
- I will be provided a copy of this authorization.
- This authorization expires on: _____. (If blank, expiration is 90 days after signature.)

_____ _____

Signature of patient/patient representative **Date**

Complete the section below only if the person requesting records is not the patient:		
Name of Representative	Relationship to Patient	Legal Authority
Representative's Address & Phone Number	Verification of Identity (Internal use only)	Verification of Authority (Internal use only)

PHI

BAPTIST HEALTH CARE

effective April 2021