BAPTIST HEALTH

Baptist Endocrinology

Medical Records Request or Release

Release of Records

Records to be sent to the following address:

Name _____

Street Address _____

City, State, ZIP _____

Reason for Release of Records _____

Request for Records

Records to be received from:

Physician/Facility _____

Address _____

City, State, ZIP _____

Release from my medical records the following information for the following dates:

From _____ To _____

_____

_____

As part of the medical record, the following information will be released unless crossed out:

SEXUAL ABUSE INFORMATION

DRUG & ALCOHOL ABUSE INFORMATION

CHILD ABUSE & NEGLECT INFORMATION

PSYCHIATRIC INFORMATION

AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed _____ Date _____

Patient, Parent or Guardian

Patient Name _____

Date of Birth _____ SS # _____

Witness _____ Date _____

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.