

AUTHORIZATION FOR RELEASE OF RADIOLOGY & IMAGING FILMS

	☐ BAPTIST MEDICAL CENTER DOWNTOWN	800 Prudential Drive, Jacksonville, FL 32207 Attn: Adult Radiology Fax: (904) 202-1031
	☐ BAPTIST MEDICAL CENTER BEACHES	1350 13 th Avenue South, Jacksonville Beach, FL 3225 Attn: Radiology Fax: (904) 627-1512
check	☐ BAPTIST MEDICAL CENTER NASSAU	1250 South 18 th Street, Fernandina Beach, FL 32034 Attn: Radiology Fax: (904) 321-1871
	□ WOLFSON CHILDREN'S HOSPITAL	800 Prudential Drive, Jacksonville, FL 32207 Attn: Pediatric Radiology Fax: (904) 202-8144
	☐ BAPTIST MEDICAL CENTER SOUTH	14550 St. Augustine Road, Jacksonville, FL 32258

IMAGING FILMS		□ BAPTIST M	EDICAL CENTER SO		St. Augustine Road, Jacksonville, FL 32258 maging Fax: (904) 271-6655		
Patient Name:				В	irth Date:		
Social Security No.:		Medical Record (MMI) No.:					
Address:				To	elephone No.:		
☐ I hereby authorize the above-refer☐ I hereby authorize the above-referecipient for purposes of my cont	renced entity to release						
Recipient Name:				To	elephone No.:		
Address:							
Films Needed: ☐ Radiology Films ☐ Magnetic Resonance Imaging (MR		Γ Scan Films					
Dates of Service Needed: □ Most Recent Examination (Date: / /) □ From: / / To: / / □ Most Recent Examination (Date: / /) □ From: / / To: / / □ Most Recent Examination (Date: / /) □ From: / / To: / / □ Most Recent Examination (Date: / /) □ From: / / To: / / □ Most Recent Examination (Date: / /) □ From: / / / □ Most Recent Examination (Date: / /) □ From: / / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / /) □ From: / / □ Most Recent Examination (Date: / / /) □ From: / / □ Most Recent Examination (Date: / / /) □ From: / / / □ Most Recent Examination (Date: / / /) □ From: / / / □ Most Recent Examination (Date: / / /) □ From: / / / □ Most Recent Examination (Date: / / /) □ From: / / / □ Most Recent Examination (Date: / / /) □ From: / / / / □ Most Recent Examination (Date: / / /							
I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any films already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Baptist Health or the above-referenced entity will not depend in any way on whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization. I understand that State and federal law may prohibit the Recipient from re-disclosing images provided pursuant to this Authorization, but that neither Baptist Health nor the above-referenced entity has any control over the Recipient and cannot therefore guarantee that the Recipient will not re-disclose such films. I understand that these films are originals and may not be replaceable and I hereby release Baptist Health and the above-referenced entity from any and all liability or consequences related to (i) their reliance upon this Authorization or (ii) the release of films pursuant to this Authorization, including, but not limited to, the unavailability of, loss of or damage to such films once they have left the above-referenced entity's premises. I will request the return of these films to the above-referenced entity after the Recipient's need for them ceases. If the above-referenced entity agrees to my request that it mail the films directly to the Recipient, I understand that the above-referenced entity may charge me a reasonable, cost-based fee for postage and I agree to pre-pay such amount. By signing below, I authorize the entity checked above to release films as described above.							
Signature of Patient			_	Date	Time		
If (i) the patient is a minor, the patient's parent or guardian should consent by signing below, or (ii) if the patient is an adult but unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:							
Signature of Representative	Date	Time	_	Telephone			
Name of Representative		Relationship to Patient					
Date Mailed:	Pate Mailed: Picked Up By: ☐ Patient or ☐ Recipient (or Recipient's Representative)						
Employee Releasing Films:			a:	onatura	Data Timo		



Baptist Medical Center Downtown, Jacksonville, FL Baptist Medical Center Beaches, Jacksonville Beach, FL Baptist Medical Center Nassau, Fernandina Beach, FL Baptist Medical Center South, Jacksonville, FL Wolfson Children's Hospital, Jacksonville, FL AUTHORIZATION FOR RELEASE OF RADIOLOGY & IMAGING FILMS



PATIENT LABEL