Organization Who Is Releasing Information			
Entity/Provider:	**Address:**		
City, State, Zip Code:		**Fax Number:**	**Telephone Number:**

Entity/Provider:	**Address:**		
City, State, Zip Code:		**Fax Number:**	**Telephone Number:**

Entity/Provider:	**Address:**		
City, State, Zip Code:		**Fax Number:**	**Telephone Number:**

Entity/Provider:	**Address:**		
City, State, Zip Code:		**Fax Number:**	**Telephone Number:**

Entity/Provider:	**Address:**		
City, State, Zip Code:		**Fax Number:**	**Telephone Number:**

I hereby authorize the above-referenced entity(s) to release the medical information about me indicated below to the following recipient:

To Whom Information Will Be Provided	Purpose of Release:	Records Being Requested:
❑ **Baptist MD Anderson Cancer Center** Attention: Medical Records Department 1301 Palm Avenue Jacksonville, FL 32207 Telephone Number: 1-844-632-2278	❑ **Continued Care** Records needed for doctor's appointment on _____ (date) at _____ (time).	❑ **Oncology Records** ❑ Other: _____ **Dates of Service Needed:** ❑ **All** ❑ Last Visit Only ❑ From: _____ To: _____

Patient Name:		**Birth Date:**		**Medical Record Number:**
Address:	**City:**	**State:**	**Zip:**	**Telephone Number:**

I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization.

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 information 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 Baptist MD Anderson Cancer Physicians 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 information provided pursuant to this Authorization, but that neither Baptist Health nor Baptist MD Anderson Cancer Physicians has any control over the Recipient and cannot, therefore, guarantee that the Recipient will not re-disclose such information. I hereby release Baptist Health and Baptist MD Anderson Cancer Physicians from any and all liability related to (i) their reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

I understand that the above-referenced entity(s) may charge me reasonable, cost-based fees for searching, preparing, copying, mailing and otherwise producing records. The above-referenced entity(s) will waive some or all such fees for copies provided to another healthcare provider for continued care.

By signing below, I authorize the above-referenced entity(s) to release medical information about me as described above.

_____ _____
Signature of Patient Date Time

If the patient is (i) a minor, the patient's parent or guardian should consent by signing below, or (ii) an adult but mentally or physically 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 Number

_____ _____
Name of Representative Relationship to Patient

BAPTIST MD Anderson Cancer Center
Jacksonville, FL

BMDA AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

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PATIENT LABEL