Authorization to Release and Obtain Medical Information - Physician Practice

Patient Name:	Birth Date:	Medical Record Number:

Address:	City:	State:	Zip:	Telephone Number:

Organization Who is Releasing Information

Entity/Individual:	Address:	
UF Health Jacksonville Physicians	655 West 8th Street	
City, State, Zip Code:	**Email Address:**	**Telephone Number:**
Jacksonville, FL, 32209	ufh@scanstat.com	904-431-0966

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

Facility:	Fax Number:
Baptist Primary Care Adminstration (Phone: 904-376-3500)	904-390-7519
Address:	**City, State, Zip Code:**
3563 Philips Highway, Suite 101	Jacksonville, FL, 32207

Records Being Requested:

❑ Office Notes	❑ Laboratory Results	❑ Cardiovascular Reports	❑ Discharge Summary
❑ History & Physical	❑ Radiology Reports	❑ Operative Reports	❑ Psychological Report
❑ Consultation Records	❑ Radiology Images	❑ Anesthesia Records	☒ Entire Record
❑ Emergency Department Records	❑ Pathology Reports	❑ Other: Past 2 years of med. records + last colonoscopy report or Cologuard Result if applicable	

Dates of Service Needed:

❑ Last Visit Only ❑ From: _____ To: _____ ☒ All (Past two years)

Purpose of Release:

☒ Continued Care*	❑ Personal	❑ Disability
❑ Research	❑ Insurance	❑ Department of Children's & Family Services (DCFS)
❑ Legal (Attorney)	❑ Other: _____	

And/Or Verbal Communication – please specify frequency:

❑ As Needed ❑ Only in session ❑ Other: _____

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 the above-referenced entity(s) 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 the above-referenced entity(s) 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 the above-referenced entity(s) from any and all liability related to (i) their reliance upon this Authorization or (ii) the release of information pursuant to this Authorization. I further understand that the Recipient may participate in an electronic medical records network, and if so, then any information released pursuant to this authorization may be accessible by other providers (and their staff) who also participate in the network. I hereby release the Disclosing Person/Entity, the Recipient and their respective directors, officers, professional staff, employees, agents, contractors, volunteers and affiliates 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 _____

AUTHORIZATION TO RELEASE AND OBTAIN MEDICAL INFORMATION - PHYSICIAN PRACTICE

Patient Name:

Date of Birth:

Medical Record #:

Financial #: