BAPTIST HEALTH

Depend On Us For Life.℠

AUTHORIZATION FOR RELEASE OF INFORMATION

PSYCHIATRIC & PSYCHOLOGICAL CARE

check where treated

☐ SOUTHSIDE	4160 University Blvd., South, Jacksonville, FL 32216 Attn: Medical Records Fax: (904)733-9598
☐ SAN MARCO	1325 San Marco Blvd., Suite 500, Jacksonville, FL 32207 Attn: Medical Records Fax: (904)733-9598
☐ BEACHES	1375 Roberts Drive, Bldg. B., Suite 201, Jacksonville Beach, FL 32250 Attn: Medical Records Fax: (904)733-9598
☐ ORANGE PARK	2300 Highway 17, Suite 201, Orange Park, FL 32073 Attn: Medical Records Fax: (904)733-9598

Patient Name:	**Birth Date:**
Social Security No.:	**Medical Record (MMI) No.:**
Address:	**Telephone No.:**

☐ I hereby authorize Psychiatric & Psychological Care to release the medical information about me indicated below to the following recipient:

Recipient:	**Telephone No.:**
Address:	**Fax No.:**

Documents Needed:
☐ Entire Record * ☐ Treatment Summary Only ☐ Other: _____

* Does not include psychotherapy notes

Dates of Service Needed:
☐ All ☐ Last Visit Only ☐ From: ___/___/___ To: ___/___/___

Purpose of Release:
☐ Continued Care *** ☐ Research ☐ Insurance
☐ Legal (Attorney) ☐ Disability ☐ Personal
☐ Dept. Children's & Family Services (DCFS) ☐ Other: _____

*** If for continued care, records needed for appointment on _____ (date) at _____ (time).

Information I do not want released under this Authorization:

I am aware that such records may contain information related to mental health, substance abuse (both alcohol and drug) and sexually transmissible 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 Psychiatric & Psychological Care 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 Psychiatric & Psychological Care may charge me reasonable, cost-based fees for any records it releases under this Authorization. Psychiatric & Psychological Care may waive such fee for copies provided to another healthcare provider for continuing care.

I understand that State and federal law may prohibit the Recipient from re-disclosing information provided pursuant to this Authorization, but that the releasing entity has no control over the Recipient and cannot, therefore, guarantee that the Recipient will not re-disclose such information. I hereby release Psychiatric & Psychological Care from any and all liability related to (i) its reliance upon this Authorization or (ii) the release of information pursuant to this Authorization.

By signing below, I authorize Psychiatric & Psychological Care to release medical information about me as described above.

_____ _____
Signature of Patient Date

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 Telephone

_____ _____
Name of Representative Relationship to Patient
