BAPTIST HEALTH

Depend On Us For Life.℠

AUTHORIZATION TO OBTAIN PSYCHOTHERAPY NOTES

PSYCHIATRIC & PSYCHOLOGICAL CARE

send my records to

☐ 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 the entity or individual listed below to release psychotherapy notes concerning me as indicated below to Psychiatric & Psychological Care at the address set forth above for purposes of continued care:

Releasing Individual or Entity Name:	**Telephone No.:**
Address:	**Fax No.:**
Dates of Service Needed:	
☐ All ☐ Last Visit Only ☐ From: ____/____/____ To: ____/____/____	

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 State and federal law may prohibit Psychiatric & Psychological Care from re-disclosing information provided pursuant to this Authorization, but that the releasing entity has no control over Psychiatric & Psychological Care. I hereby release the releasing entity 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 the release of psychotherapy notes concerning 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
