

Baptist Facility Who is Releasing Information			
<input type="checkbox"/> Baptist MD Anderson Cancer Center - Jacksonville 1301 Palm Avenue, Jacksonville, FL 32207 Phone: (904) 202-7166 Fax: (904) 202-7559 Email: BMDARecordsRelease@bmcjax.com		<input type="checkbox"/> Baptist MD Anderson Cancer Center - South 14546 Old St. Augustine Road, Medical Office Bldg. 1, Jacksonville, FL 32258 Phone: (904) 202-7166 Fax: (904) 202-7559 Email: BMDARecordsRelease@bmcjax.com	
<input type="checkbox"/> Other Facility:		Fax Number:	
Address:		City, State, Zip Code:	

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

To Whom Information Will Be Provided			
Entity/Individual:		Address:	
City, State, Zip Code:		Fax Number:	
Email Address:		Telephone Number:	

☐ **Send Records via Unencrypted Email.** Please be advised that unencrypted communications are not secure and there is some level of risk that a third party could see or intercept your Protected Health Information (PHI) without your consent when receiving unencrypted electronic media or email. We are not responsible for any unauthorized access to your PHI or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in unencrypted electronic format or email. By choosing delivery by unencrypted email, you acknowledge that you understand the risks explained above.

☐ **Send Records to My Baptist Chart**

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

Records Being Released:			
<input type="checkbox"/> Abstract (all asterisked items)	<input type="checkbox"/> Emergency Department Records*	<input type="checkbox"/> Cardiovascular Reports*	<input type="checkbox"/> Current Medications*
<input type="checkbox"/> History & Physical/Intake*	<input type="checkbox"/> Laboratory Results*	<input type="checkbox"/> Operative/Procedure Reports*	<input type="checkbox"/> Psychological Reports
<input type="checkbox"/> Consultation Records*	<input type="checkbox"/> Radiology Reports* (no images)	<input type="checkbox"/> Immunizations/Allergies*	<input type="checkbox"/> Progress/Office Notes
<input type="checkbox"/> Discharge/Clinical Summary*	<input type="checkbox"/> Pathology Reports*	<input type="checkbox"/> Other: _____	

Images Needed:			
<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Ultrasound (Sonogram) Images	<input type="checkbox"/> CT Scan Images	<input type="checkbox"/> All Images
<input type="checkbox"/> Magnetic Resonance Imaging (MRI) Images	<input type="checkbox"/> Nuclear Medicine Images	<input type="checkbox"/> Other: _____	

Dates of Service Needed:	
<input type="checkbox"/> Last Visit Only	<input type="checkbox"/> From: _____ To: _____

Purpose of Release:	
<input type="checkbox"/> Continued Care*	<input type="checkbox"/> Personal
<input type="checkbox"/> Research	<input type="checkbox"/> Insurance
<input type="checkbox"/> Legal (Attorney)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Disability <input type="checkbox"/> Department of Children's & Family Services (DCFS)	

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

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.

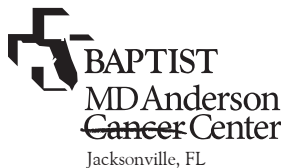
Signature of Patient	Date	Time
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If the patient is (i) a minor, the patient's parent or guardian should consent by signing below, or (ii) an adult but mentally or physically unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact, surrogate or proxy should consent on the patient's behalf by signing below:

Signature of Representative	Date	Time	Telephone Number
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Name of Representative	Relationship to Patient
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This information has been disclosed to you from records whose confidentiality is protected from disclosure by state and federal law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written authorization of the individual to whom it pertains, their authorization representative, or as otherwise permitted by law. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.



**BMDA AUTHORIZATION TO
RELEASE MEDICAL INFORMATION
AND RADIOLOGY IMAGES**



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PATIENT LABEL