BAPTIST HEALTH SOUTH FLORIDA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Format requested:

Delivery Method: ☐ Mail or ☐ Pick-up Date _____ *Records will automatically be mailed after 10 days unless there is a fee.
☐ Paper ☐ Fax ☐ E-mail ☐ USB Drive or ☐ CD *(Imaging Department only)*

Availability of electronic format depends on date facility started storing electronic data

I hereby authorize the use and/or disclosure of the below named individual's health information as described below:

1. I hereby authorize the following individual(s) or organization(s): ☐ Baptist Hospital of Miami ☐ South Miami Hospital ☐ Doctors Hospital ☐ Homestead Hospital ☐ West Kendall Baptist Hospital ☐ Baptist Outpatient Services ☐ Ambulatory Surgery Center ☐ Mariners Hospital ☐ Diagnostic Center ☐ Urgent Care Center ☐ Baptist Health Medical Group Physician Practice ☐ Miami Cancer Institute ☐ Fishermen's Community Hospital

☐ Other: (specify): _____ to make the disclosure of health information in the manner described herein.

Patient Name: _____ Phone #: _____ D.O.B.: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

2. The health information described below may be used by or disclosed to the following:
☐ ***SELF: Select this option if the records are for yourself; otherwise, indicate whom you want your records released to:***

☐ Name of person/organization: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email address: _____ Fax #: _____

3. Check the health information you are authorizing to be used/disclosed:

☐ Dictations/Tests Results	☐ Consultations	☐ Medication	☐ Radiology Images
☐ Emergency Record	☐ Progress Notes	☐ Radiology Reports	☐ Pathology Slides
☐ Discharge Summary	☐ Laboratory	☐ Pathology Report	☐ Cath Lab cine / CD
☐ Operative Record	☐ Physician Orders	☐ Other_____	

_____ Initial here for HIV tests and results. You must obtain initial HIV Antibody testing information from your physician.

_____ Initial here for records relating to our Addiction Treatment and Recovery Center at South Miami Hospital. If this form authorizes the use/disclosure of Addiction Treatment and Recovery Center records from South Miami Hospital, it may not be used to authorize the use and disclosure of any other health information. A separate authorization is needed for any other use/disclosure.

4. Approximate date(s) of treatment or event: _____

5. This request is being made for: ☐ Continuation of Care *or* ☐ Other, e.g., self, insurance, legal purposes: _____

6. I understand that I have the right to revoke this authorization at any time, and that if I revoke this authorization, I must send a written request to: **Baptist Health South Florida, 8500 SW 117 Avenue, Box 7, Miami, FL 33183, attention PHI Manager**. I understand that the revocation will not apply to information that has already been released in reliance on this authorization and to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Authorization will expire one year from the date on which it was signed unless another date or event is specified: _____
Note: If you are requesting a release of records please ensure that any expiration date or event allows sufficient time for your records to be prepared and sent to the party identified.

8. I understand that this authorization is voluntary. I understand that once the health information described herein is disclosed, it may be re-disclosed by the recipient and may no longer be protected by federal privacy laws; however, under federal and state laws respectively, the recipient may be prohibited from re-disclosing substance abuse and HIV/AIDS information without specific written consent of the person to whom it pertains, or as otherwise permitted by such laws. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

_____	_____	_____	_____
Signature of Patient*/Personal Representative	Relation to Patient	Date	Time

*The above individual is unable to consent because (check one): ☐ Minor ☐ Incompetent ☐ Other (explain):_____

Account #: _____ MR #: _____ Processed by *(print employee name)*: _____

If not processed, this form MUST be sent via interoffice mail to Medical Records for processing.

*Fees for medical records will be charged in accordance with applicable State and Federal regulations:

- F.S. 395.3025 – Fees for medical record copies related to Health facilities and ambulatory surgery
- F.S. 456.057 – Fees for medical record copies related to Healthcare practitioners and physicians' offices
- 45 CFR (§164.524)(c)(4) – Fees for electronic copy of records

You are entitled to a copy of this authorization after you sign it.