Organization Who is Releasing Information		
Entity/Individual:	**Address:**	
City, State, Zip Code:	**Fax Number:**	**Telephone Number:**

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

JOI Facility To Whom Information Will Be Provided		
❑ **Baptist South** 14534 Old St. Augustine Road, # 3210, Jacksonville, FL 32258 **Attn: Medical Records** Phone: (904) 880-1260 Fax: (904) 880-1210	❑ **San Marco** 1325 San Marco Blvd., Suite 200, Jacksonville, FL 32207-8566 **Attn: Medical Records** Phone: (904) 346-3465 Fax: (904) 391-1785	
❑ **Beaches** 1577 Roberts Drive, Suite 225, Jacksonville Beach, FL 32250-3265 **Attn: Medical Records** Phone: (904) 241-1204 Fax: (904) 241-7331	❑ **Nassau** 1348 S. 18th Street, Suite 320B, Fernandina Beach, FL 32034-4729 **Attn: Medical Records** Phone: (904) 261-8787 Fax: (904) 261-9353	
❑ **Fleming Island** 1747 Baptist Clay Drive, Suite 200, Fleming Island, FL 32003-8505 **Attn: Medical Records** Phone: (904) 276-5776 Fax: (904) 276-5958	❑ **JOI Rehab Location:** Address: **Attn: Medical Records** Phone: Fax:	
❑ **Other Facility:**		**Fax Number:**
Address:	**City, State, Zip Code:**	

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

Records Being Requested:

- ❑ **Entire Record** *(no Radiology Images)*
- ❑ **Entire Record** *(with Radiology Images)*
- ❑ History & Physical
- ❑ Consultation Records
- ❑ Emergency Department Records
- ❑ Laboratory Results
- ❑ Radiology Reports *(no Radiology Images)*
- ❑ Pathology Reports
- ❑ Cardiovascular Reports
- ❑ Operative Reports
- ❑ Anesthesia Records
- ❑ Other: ____
- ❑ Discharge Summary

Dates of Service Needed:

❑ All ❑ Last Visit Only ❑ From: ____________________ To: ____________________

Purpose of Release:

- ❑ Continued Care*
- ❑ Research
- ❑ Legal (Attorney)
- ❑ Personal
- ❑ Insurance
- ❑ Other: ____________________________________
- ❑ Disability
- ❑ 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.

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 OBTAIN MEDICAL INFORMATION

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PATIENT LABEL