Baptist Health

1938

H229

Authorization for Baptist Health
To Disclose Information to Others

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of records from Baptist Health to the organization listed below:

Name: _____

Address: _____

Phone: _____

Dates of Service for Request _____ **Format** _____Paper _____Electronic

Information Requested

_____Summary Report (diagnostic results and physician notes)
_____Operative/Pathology Report
_____Medication Records
_____Other _____

_____Entire Medical Record
_____Lab/X-Ray
_____Immunization Records
_____EKG

The purpose of this request is

_____Medical Care _____Insurance _____Personal Records _____School/Work _____Legal _____Other

I understand that I may revoke this authorization at any time by sending a written notice to the address above. I understand that any release which has been made prior to such revocation and which was made in reliance upon this authorization shall not constitute a breach of my privacy rights. I understand that my ability to receive treatment is not conditioned on my signing this form. NOTICE: This authorization will expire in one year. Once information has been disclosed in accordance with this authorization, it may be re-disclosed to individuals or organizations that are not subject to HIPPA.

_____ _____
Signature of Patient or Legal Representative Date Relationship, if not the patient

SPECIFIC INFORMATION FOR RELEASE OF DRUG/ALCOHOL ABUSE INFORMAITON AND/OR MENTAL HEALTH INFORMATION
I acknowledge that the information released MAY INCLUDE material that is protected by Federal law. My additional signature authorizes release of such information.

_____ _____
Signature of Patient or Legal Representative Date Relationship, if not the patient

This form can be mailed or faxed to BHMC- Little Rock Attn: Medical Records Department 9601 Baptist Health Drive Little Rock, AR 72205. Phone (501) 202-1914, Fax (501) 202-1249.

Revision Date: December 2023
Approved by: Systems Forms Committee