Name of Baptist Facility: ______________________________

PATIENT'S NAME: ______________________________ BIRTH DATE: ______________

Last 4 digits of SSN: ____________________ PHONE #: ______________________

ADDRESS: ______________________________

I authorize Baptist to disclose my health information to:

____

Specify: Name of Attorney, Insurance Company, etc. (Name and address are needed when disclosing to a third party.)

Requested dates of treatment from: ____________________ to: ____________________

Information to be disclosed:

☐ Abstract (Example: History and Physical, Discharge Summary, Operative Report, and Pathology Report, if applicable)

☐ Emergency Department Record ☐ Entire encounter ☐ Itemized bill ☐ Radiology images

☐ Monitor Strips ☐ Secure Chat Text Messages ☐ Tracings or other graphic data ☐ Photographs/Videos

☐ Outside Records ☐ Other ______________________________

Method of Disclosure:

☐ Paper ☐ Compact Disc (CD) ☐ MyChart ☐Other: ______________________________

Unless you specifically direct otherwise in this request, records released may include information about STI/STD's, HIV/AIDS, cancer, pregnancy history, mental health diagnoses, substance use/abuse, and medications taken for treatment of any of these conditions.

______________________________	______________________________
Date	Patient/Patient Representative Signature

(Date and signature are required when disclosing to a third party.)

PATIENT DIRECTED REQUEST FOR PROTECTED HEALTH INFORMATION

▼ Patient Label ▼

Form # 0115.490 (10/17)