BMG FAMILY PHYSICIANS GROUP FOUNDATION, INC.
AUTHORIZATION TO RELEASE PHI
PHYSICIAN PRACTICES

Clinic Name: BMG Family Physicians Group **Phone #**_____**Fax#** _____

Address:_____

PATIENT'S NAME: _____BIRTH DATE:_____Chart #: _____

ADDRESS: _____ Phone #:_____Last 4 digits of SS #:_____

I authorize Baptist or the following person or organization (specify if applicable) _____ to:

☐ **disclose** my health information to:_____

_____

(Name and Address) - Specify: Attorney, Insurance, Self, etc

☐ **obtain/request** copies of my health information from: _____

_____

(Name and Address) - Specify: Hospital, Doctor, etc

Purpose of use, disclosure, and or request: ☐ Continuation of Care/Treatment ☐ Attorney ☐ At the request of the patient ☐ Payment ☐ Other, specify: _____

I authorize use and/or disclosure of information covering treatment from: _____to: _____
(enter specific dates)

Information to be used and/or disclosed:

☐ History and Physical ☐ Progress Note ☐ Lab ☐ Radiology/Imaging ☐ All records ☐ Itemized bill
☐ Outside Records ☐ Secure Chat Text Messages
☐ Other (Specify): _____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).

This release will include information I have previously restricted from my health plan unless I initial here. ☐

This authorization will expire one year from the date of your signature unless you specify a different expiration date, event, or condition. Please specify: _____

I understand that I have a right to revoke this authorization at any time, except to the extent that release of information has already occurred in reliance on my prior authorization.

I understand that in order to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to the Director of Health Information Management at the Baptist facility indicated above. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as workers' compensation, private health insurance, application for insurance, etc., my refusal to sign may effect payment, enrollment or eligibility for benefits. This, in turn, may effect payment for services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

When Baptist **seeks** an authorization for its own use or disclosure of protected health information (e.g., marketing, research, etc.), a **copy** of the authorization is provided to the patient.

_____ _____
Date Patient (or person authorized to consent for minor or patient who is unable to sign)

_____ _____
Witness Relationship and/or authority to act for the patient

Photo ID was provided: Yes ☐ No ☐ If no, specify form of patient identification:_____

Rev. 10/2017