baptisthealth centers
LIVING THE MISSION- WE ARE HERE FOR YOU

AUTHORIZATION FOR PATIENT INFORMATION

Release of Information

________ I DO NOT wish to have test results or other medical information released to any person other than myself.

________ I DO wish to have test results or other medical information released to the following person(s).

NAME ____________________ RELATIONSHIP ____________________

NAME ____________________ RELATIONSHIP ____________________

NAME ____________________ RELATIONSHIP ____________________

NAME ____________________ RELATIONSHIP ____________________

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patent must file another Authorization for Release of Patient Information with this clinic.

Please understand that it may be necessary for us to disclose some or all of the information contained in your medical records to other physicians, nurses and/or healthcare providers (collectively referred to as "providers"). At times, other providers assist us in assessing a patient's condition, screening for potential problems, or providing consultation under certain circumstances. All healthcare providers are required by law to maintain our patient confidentiality.

Also, due to the increased awareness of quality care and outcomes measurements, it may be necessary to disclose information regarding your care to healthcare agencies (both private and governmental), your insurance company and/or your self-insured employer. Regarding the information going to your employer, other than information needed to verify your insurance coverage; the data released will consist of statistical information only.

Electronic Medication History

Eprescribing is defined as a physician's ability to electronically send an accurate, error free, and timely prescription directly to a pharmacy from the point of care. To optimize this electronic capability, and coordinate your care, we ask your permission to obtain electronic medication history of prescriptions prescribed by other providers.

Please select one of the following:

________ I DO allow my provider to access all of my medication history including medications prescribed by other providers.

________ I DO NOT allow my provider access to any of my medication history except for prescriptions prescribed in this office.

Patient Signature ____________________ Date ____________________

Printed Name ____________________ Doctor ____________________

Witness ____________________ Date of Birth ____________________