Record Request: Authorization to Use and Disclose Radiology Imaging

This authorization shall apply to all of the following entities: Baptist Health Care, Inc., Jay Hospital, Inc., Baptist Medical Group, LLC, Baptist Urgent Care, LLC.

Patient's Name	Date of Birth	Medical Record #
Patient's Address	City	State Zip
Phone #	E-mail Address	

By signing this form, I authorize the release of Radiology Imaging as follows:

FROM the doctor, office or facility written below :	**TO the facility / person written below :**
	☐ **Check here if same as patient**
Hospital, Clinic, person or organization	Hospital, Clinic, person or organization
Attn:	Attn: **(for Substance Use Disorder records- name of PERSON is required)**
Address	Address
Phone Fax	Phone Fax

The following imaging may be released *(check boxes below)*:

☐ All Imaging	☐ Magnetic Resonance Imaging (MRI)	☐ Ultrasound (Sonogram)
☐ PET/CT	☐ X-Ray Imaging	☐ Computed Tomography (CT) Scan
☐ Mammography Films	☐ Nuclear Medicine	☐ Other:

Are there specific dates needed? _____ **Dates** _____

Purpose of this request?	☐ Insurance Claim ☐ Legal Purposes ☐ At the Request of the Patient ☐ Medical Treatment – Physician Name:_____ ☐ Other:_____
Format of Records?	☐ Pick Up Disc ☐ Mail Disc ☐ Powershare (for doctors/office/facility)

Please mail or fax completed form to:

*This fax and address are only for this form. Incoming medical records should be sent to the Requestor location above.

Baptist Health Care Imaging

123 Baptist Way
Pensacola, FL 32503

Fax 850.908.4028
Phone 448.227.3500
BHCRadiologyImaging@bhcpns.org

This authorization allows any and all of the providers listed above to use and disclose certain PHI, which includes imaging, as I have directed. **I understand that:**

- I have a right to request a list of disclosures of my medical information, if requested in writing.
- I have a right to revoke this authorization at any time by providing written notice to BHC Request of Information, P.O. Box 17804, Pensacola, FL 32522-17804. I understand that the revocation will not apply to information that has already been released in response to this authorization or if the authorization was obtained as a condition of obtaining insurance coverage where the law provides my insurer with the right to contest a claim under my policy.
- Except for Substance Use Disorder and HIV (AIDS) records, once my PHI is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws.
- I understand that if I refuse to sign this authorization, my treatment, payment, enrollment or eligibility for benefits will not be affected.
- I will be provided a copy of this authorization.
- This authorization expires on: _____. (If blank, expiration is 90 days after signature.)

_____ _____

Signature of patient/patient representative **Date**

Complete the section below only if the person requesting records is not the patient:		
Name of Representative	Relationship to Patient	Legal Authority
Representative's Address & Phone Number	Verification of Identity (Internal use only)	Verification of Authority (Internal use only)

BAPTIST HEALTH CARE

PHI