

# Baptist

**Physician Network**  
Affiliated with Baptist Hospitals of Southeast Texas  
Performing Sacred Work Everyday

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: \_\_\_\_\_

Last

First

Middle Initial

Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I request a copy of medical records from \_\_\_\_\_ (date) to \_\_\_\_\_ (date)

On the above named patient for the following reason(s):

\_\_\_\_\_ Change in Primary Care Provider

\_\_\_\_\_ Moving or Relocating to another area

\_\_\_\_\_ Other: (please explain) \_\_\_\_\_

**From:** \_\_\_\_\_

Name of Releasing Physician or Facility

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**To:** \_\_\_\_\_

Physician, Facility, or Person receiving Records

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Representative

\_\_\_\_\_  
Date

I hereby authorize the release of all medical records except notes forwarded by a mental health professional, such as a Psychiatrist, Psychologist, or a Licensed Professional Counselor. I hereby release BAPTIST PHYSICIAN NETWORK from liability associated with this release.

Please complete all fields on this form. Omitted information may cause a delay in your request. 01/16

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