Baptist
Physician Network
Family Medicine Clinic
Performing Sacred Work Every Day

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