CORREQ

Name of Baptist Facility: _____

PATIENT'S NAME: _____ BIRTH DATE: _____

Last 4 digits of SSN: _____ PHONE #: _____

ADDRESS: _____

I authorize Baptist to disclose my health information to:

_____

Specify: Name of Attorney, Insurance Company, etc. (Name and address are needed when disclosing to a third party.)

Requested dates of treatment from: _____ to: _____

Information to be disclosed:

☐ Abstract (Example: History and Physical, Discharge Summary, Operative Report, and Pathology Report, if applicable)

☐ Emergency Department Record ☐ Entire encounter ☐ Itemized bill ☐ Radiology images

☐ Other _____

Method of Disclosure:

☐ Paper ☐ Compact Disc (CD) ☐ MyChart ☐Other: _____

Unless you specifically direct otherwise in this request, records released may include information about STI/STD's, HIV/AIDS, cancer, pregnancy history, mental health diagnoses, substance use/abuse, and medications taken for treatment of any of these conditions.

_____ _____

Date Patient/Patient Representative Signature

(Date and signature are required when disclosing to a third party.)

BAPTIST

PATIENT DIRECTED REQUEST FOR PROTECTED HEALTH INFORMATION

▼ Patient Label ▼