



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
- Monitor Strips    Secure Chat Text Messages    Tracings or other graphic data    Photographs/Videos
- Outside Records    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.)



▼ Patient Label ▼

**PATIENT DIRECTED REQUEST FOR  
PROTECTED HEALTH INFORMATION**