

## Declaration

I, \_\_\_\_\_ (name of patient) hereby give authorization to Baptist Health for the release of information concerning the status of my health care, including results of laboratory and radiology tests and to discuss my plan of treatment with:

\_\_\_\_\_  
Name of Authorized Individual

\_\_\_\_\_  
Relationship to Patient

I understand that I may revoke this authorization at any time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date