

Declaration

I, _____, on behalf of myself (as patient), or on behalf of the patient (as surrogate/proxy), hereby give authorization to Baptist Health, or its affiliates, for the release of information concerning the status of my health care, including results of laboratory and radiology tests and to discuss the plan of treatment with:

Name of Authorized Individual

Relationship to Patient

Phone Number

Name of Authorized Individual

Relationship to Patient

Phone Number

I am aware that such discussion or disclosure may include information related to mental health, substance abuse (both alcohol and drug) and sexually transmitted diseases (including test results related to HIV/AIDS), and I specifically authorize the release of such information pursuant to this Authorization. I understand that I may revoke this authorization at any time.

Signature of Patient or Healthcare Surrogate/Proxy

Date

Time

Witness

Date

Time



CONSENT FOR HEALTH CARE STATUS



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PATIENT LABEL