

Health Care Status Authorization

I, _____ (name of patient)
hereby give authorization to Baptist Primary Care 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

In consideration, I release Baptist Primary Care, its subsidiaries and affiliates as well as its agents and employees from and do hereby waive any and all claims that I may now or hereafter have for damages of any kind resulting from the release of information to the individual designated above.

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

Patient Signature

Witness

Date