

**BAPTIST PRIMARY CARE  
MEDICAL RECORDS REQUEST OR RELEASE**

**RELEASE OF RECORDS**

**Records to be sent to the following address:**

NAME: \_\_\_\_\_ H. Dale Boyd, MD - Baptist Primary Care \_\_\_\_\_

ADDRESS: \_\_\_\_\_ 1590 Island Lane, Suite 1 \_\_\_\_\_

\_\_\_\_\_ Orange Park, FL 32003 ( tele 904.264.4405 fax 904.264.4368) \_\_\_\_\_

Reason for Release of Records: \_\_\_\_\_

**REQUEST FOR RECORDS**

**Records to be received from:**

PHYSICIAN/FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Release from my medical records the following information for the following dates: From: \_\_\_\_\_  
To: \_\_\_\_\_

As part of the medical record, the following information will be released unless stricken:

**SEXUAL ABUSE INFORMATION  
DRUG & ALCOHOL ABUSE INFORMATION  
CHILD ABUSE & NEGLECT INFORMATION  
PSYCHIATRIC INFORMATION  
AIDS/HIV**

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which it is addressed only. The confidentiality of this information is protected by federal law. The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from date of signature.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient, Parent or Guardian)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.