

## 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

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

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

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date