



HEALTH CARE STATUS AUTHORIZATION

I, _____ (name of patient),
Hereby given 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

Address of Authorized Individual

Telephone Number of Authorized Individual

Relationship of Patient

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

Patient Name (Please Print)

Patient Signature

Witness

Date