Orange Park Pediatrics

Baptist Primary Care

PARENTAL AUTHORIZATION FOR MEDICAL CARE

For families who are ongoing patients of ORANGE PARK PEDIATRICS it may be more convenient to have prior authorization for medical care delivered to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you wish to authorize treatment in advance.

I/we request and authorize Orange Park Pediatrics and its personnel to deliver medical care to my/our child/children listed below:

PLEASE PRINT CHILD/CHILDREN'S NAME

NAME _____ DOB _____

NAME _____ DOB _____

NAME _____ DOB _____

I/we authorize the following people to bring in my child/children for treatment:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

Please try to contact me/us regarding the health care of my/our child/children at the following phone numbers:

PARENT'S NAME _____

PHONE _____

PARENT'S NAME _____

PHONE _____

OTHER NAME _____ RELATIONSHIP _____

PHONE _____

SIGNATURE _____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain in the space below.

_____

_____

_____

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MEDICAL RECORDS RELEASE TO ORANGE PARK PEDIATRICS

Records to be sent to the following address:

NAME: **Orange Park Pediatrics, Baptist Primary Care**
(Please check below the correct address for your selected location.)

	Address				Phone	FAX
☐	2140 Smith Street	Orange Park	FL	32073	904/269-2140	904/264-3018
☐	6353 Argyle Forest Blvd., #4	Jacksonville	FL	32244	904/908-0200	904/908-3915
☐	1747 Baptist Clay Dr., #110	Fleming Island	FL	32003	904/520-6620	904/215-2981

****PLEASE MAIL ALL RECORDS TO ABOVE CHECKED ADDRESS AND FAX IMMUNIZATION TO ASSOCIATED FAX NUMBER**

Reason for Release of Records: _____

Records to be received from:

Physician/facility: _____

Address: _____

Phone: _____ **Fax:** _____

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 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.

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NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of a copy of the Baptist Primary Care (BPC) Notice of Privacy Practices (NPP) either at this time or previously. By accepting services at BPC, I authorize BPC to use and disclose information from and release copies of my (the patient's) medical records in accordance with BPC's policies and privacy practices, which are summarized in the NPP, including disclosure to my (the patient's) past, present and future healthcare providers. Your information will not be released or sold to any 3rd parties.

PATIENT NAME: _____ **DOB:** _____

PATIENT NAME: _____ **DOB:** _____

PATIENT NAME: _____ **DOB:** _____

PATIENT NAME: _____ **DOB:** _____

I wish to be contacted in the following manner (check all that apply) concerning the patients shown above.

☐ **E-Mail** _____

☐ **Home Phone #** _____

☐ **Cell Phone #** _____

☐ **Work Phone #** _____

☐ **OK to leave / send detailed information via my home and/or work answering machine or cell phone voicemail or e-mail concerning appointment, referral and test information.**

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

☐ **Leave / send message with callback information only.**

If the patient is 18 years of age or older, please list names of those that your medical information can be released to below.

Name:	**Relationship:**	**Name:**	**Relationship:**
_____		_____	
_____		_____	

_____ _____

SIGNATURE OF PATIENT or PARENT (GUARDIAN) DATE