

Orange Park Pediatrics



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.)

<u>Address</u>	<u>Phone</u>	<u>FAX</u>
<input type="radio"/> 2140 Smith Street Orange Park FL 32073	904/269-2140	904/264-3018
<input type="radio"/> 6353 Argyle Forest Blvd., #4 Jacksonville FL 32244	904/908-0200	904/908-3915
<input type="radio"/> 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 re-disclosure 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.