Orange Park Pediatrics

Baptist Primary Care

MEDICAL RECORDS REQUEST FROM ORANGE PARK PEDIATRICS

Records to be sent to the following address:

PHYSICIAN/FACILITY: _____

ADDRESS: _____

Reason for Release of Records: _____

Records to be received from Orange Park Pediatrics located at:

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

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.