

# Orange Park Pediatric Associates

Affiliated with  Baptist Primary Care

## REQUEST FOR RECORDS

### Records to be sent to the following address:

PHYSICIAN/FACILITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Reason for Release of Records: \_\_\_\_\_

### Records to be received from:

NAME: Orange Park Pediatrics      PHONE: 904-269-2140      FAX: 904-264-3018

ADDRESS: 2140 Smith Street

Orange Park, FL 32073

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.