FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

HIPAA/Disclosure/Authorization **Date / /**

I understand that this form applies to ALL providers of First Physicians Group. It is my responsibility to notify First Physicians Group of any changes.

Patient Name: ____ **DOB:** _____/_____/_____
Please Print *(First Name)* *(M.I.)* *(Last Name)*

Please note: First Physicians Group will only share information with person(s) listed below

A: I give permission to share the following information with the person(s) listed below:

Name	***Contact Number***	***Relationship***	***Appointment***	***Billing***	***Medical***

*Please note: I understand pediatric patients will be seen when accompanied by parent(s)/legal guardian or person listed in part **B** of this form and have received a copy of the Pediatric Delegate Overview*

B: If completing this form for a child I authorize the following person(s) (other than legal guardians) named below to bring my child in for an appointment and/or make medical decisions if/when I am unavailable:

Name	***Relationship to child***	***May bring my child to an appointment (Please initial)***	***May make medical decisions for my child (Please initial)***

Printed Name: ______________________________ **Signature:** ______________________________

Relationship to Patient: ______________________________ **Date:** ____/____/_____

This form expires one (1) year from the date signed and a new one must be completed.