FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

HIPAA/Disclosure/Authorization

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 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.