Palm Beach Obstetrics & Gynecology

MEDICAL RECORDS RELEASE

I authorize the release of any medical information necessary to process any insurance claim(s). I permit a copy of this authorization to be used in place of the original. The following person(s) can have access to my medical information:

_____

Relationship to patient: _____

OR ☐ Do not leave me a message or release information to anyone. Speak directly with me before releasing medical information.

By signing this authorization, I understand that medical records/lab results released may contain information related to HIV status, AIDS, sexually transmitted diseases and other personal information.

_____ _____
Signature Date

CONSENT FOR TREATMENT OF A MINOR

According to Florida law, a parent or legal guardian must consent to the treatment of a minor (any person under 18 years of age), except under certain circumstances listed below. In circumstances when the minor has the legal right to consent, Florida law prohibits the release of the minor's medical records for such treatment without the minor's written consent.

I the undersigned, as the parent or legal guardian of _____ (the 'minor) authorize, request and consent for the performance of office procedures deemed necessary by the physicians and their staff. I agree that treatment may be provided in my absence. This consent shall remain in effect unless revoked in writing.

_____ _____
Name of parent or legal guardian Relationship

_____ _____
Signature of parent or legal guardian Date

CONSENT BY MINOR PATIENT (Under limited circumstances)

I authorize, request and consent for the performance of office procedures deemed necessary by the physicians and their staff. I have the legal authority to consent to such treatment because I am (check one or more of the following):

☐ An emancipated minor: emancipated by court (must provide court order), or I do not reside with my parents and I am financially independent.
☐ Married, divorced or widowed (must provide copy of court document)
☐ A mother consenting to treatment of my child. (ex: Minor consenting to her child's circumcision)
☐ Pregnant and consenting to treatment of my pregnancy.
☐ Consenting to treatment of sexually transmitted diseases.
☐ Consenting to treatment related to family planning (birth control and/or pregnancy).

_____ _____
Signature Date

Please be advised that some procedures require a specimen to go to the lab for analysis. These procedures include PAP smears, biopsies, urine and blood samples. Our office will not charge you for these services. The lab will bill you or your insurance directly.