CONSENT FOR TREATMENT
AND CONDITIONS OF ADMISSION

1. Medical and Surgical Consent.

   a. I recognize that I have a condition requiring medical care and I hereby consent to such medical care and treatment and such diagnostic tests at Baptist Health Care Corporation, Inc. (the "Hospital") as the physicians and staff at the Hospital may deem necessary or advisable. I hereby consent to photographs, videos, digital images that may be recorded to document my care or used for internal education, performance improvement or scientific purposes. I consent to any x-ray examination, laboratory procedures, urine drug screen, blood drug screen, anesthesia, medical, surgical or dental treatment or Hospital services rendered to me under the general and special instructions of the physician/dentist. My consent, as signified by my signature below, shall apply to my child if born during my admission or treatment at Hospital.

   b. I understand that if I am pregnant, my physician may determine that it is necessary to take urine or blood samples to perform drug screens, and I consent to both the taking of the samples and the performance of the screens.

   c. I understand and acknowledge that this facility participates in the education of health care personnel and that students may be involved in the care I receive.

   d. I understand that an explanation of the risks, benefits and alternatives of any medical or surgical procedure performed by my physician will be explained to me by my physician except in an emergency situation.

   e. I UNDERSTAND AND AGREE THAT, AS A PATIENT, MY ATTENDING PHYSICIAN IS DIRECTING MY CARE, AND I RECOGNIZE THAT NONE OF THE PHYSICIANS PROVIDING CARE TO ME INCLUDING, BUT NOT LIMITED TO, EMERGENCY ROOM PHYSICIANS, HOSPITALISTS, SURGEONS, RADIOLOGISTS, PATHOLOGISTS AND ANESTHESIOLOGISTS, ARE EMPLOYED BY THE HOSPITAL. PHYSICIANS HAVE PERMISSION TO USE THE HOSPITAL FACILITIES AND MAY TAKE EMERGENCY CALLS FOR THE HOSPITAL BUT ARE INDEPENDENT CONTRACTORS AND NOT AGENTS OR EMPLOYEES OF THE HOSPITAL EVEN THOUGH THEY MAY WEAR GARMENTS OR IDENTIFICATION THAT INCLUDE THE HOSPITAL'S NAME OR LOGO. **I EXPRESSLY AGREE TO RELEASE AND DISCHARGE THE DUTY OF THE HOSPITAL AS TO SERVICES THAT MAY BE PERFORMED BY PHYSICIANS WHO ARE INDEPENDENT CONTRACTORS, BUT NOT EMPLOYEES, OF THE HOSPITAL. I UNDERSTAND THAT BY RELEASING AND DISCHARGING THE HOSPITAL OF ITS DUTY AS TO THESE SERVICES, I AM GIVING UP THE RIGHT TO HOLD THE HOSPITAL LIABLE FOR THE POTENTIAL NEGLIGENCE OF THE PHYSICIANS.**

2. Release of Information. I authorize the Hospital to disclose all or any part of my record, including my medical records, to any person or entity that may be liable to the Hospital or me for all or part of the Hospital's charges, including, but not limited to: a) hospital or medical service companies; b) insurance companies; c) workers' compensation carriers; d) welfare or social services agencies; e) my employer; f) any entity that provides pharmaceutical products or services to the Hospital for my benefit and that offers reimbursement to the Hospital for the provision of those products and services. All such disclosures will be conducted in accordance with applicable laws. I further agree to release the Hospital, its employees, agents and assigns, and representatives from any and all liability arising out of the release of my records pursuant to this paragraph.

3. Consent for Testing and Sharing of Test Results. If, in the course of my medical care, a health care worker is exposed to my blood or other bodily fluids I give consent for a sample of my blood to be tested for HIV or Hepatitis B antibodies. I understand and acknowledge that the health care worker will be notified of the results for purposes of his or her treatment. I will also be notified of the results.

4. Personal Valuables. I understand the Hospital is not responsible for the safekeeping of my personal belongings such as money, jewelry, dentures, hearing aids, eyeglasses, watches, credit cards, or phones.

5. Assignment of Insurance Benefits. I assign payment of all applicable insurance payments directly to the Hospital and agree that the Hospital may receive any such payment, and I further understand and agree that I will be responsible for charges not covered by this assignment. I assign any state disability benefits to which I may be entitled. I appoint the Hospital as my legal representative under Florida Statutes sec. 316.066 for the sole purpose of obtaining police or crash reports and other data related to the accident or incident for which I sought treatment at the Hospital.

Patient Identification

6. Medicare-Medicaid Patients Certification. I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize the release of all records, including but not limited to medical records, required to act on this request and that payment of authorized benefits be made directly to the Hospital and the physician involved in my care for any services furnished me by the Hospital and said physicians.

7. Indigent Drug Program. If I qualify for assistance, I agree to comply with the policies of the Hospital's drug program for indigents, which may provide me with replacement of certain medications and/or copay assistance. I consent to participate in this program and authorize the Hospital to sign all forms and applications pertaining to patient assistance and co-pay programs on my behalf.

8. Patient Information Packet. I acknowledge that I have been offered Hospital's Patient Admission Packet, which includes the notice of patients' rights and the Notice of Privacy Practices.

9. Emergency Care. I understand that if I come to the Hospital's dedicated emergency department seeking care, I will be screened for an emergency medical condition and, if I have an emergency medical condition, the Hospital will provide stabilizing treatment, admit me to the Hospital as an inpatient, or transfer me if medically needed. The screening and the stabilization will be provided **regardless of my ability to pay.** I certify that the Hospital has not withheld, delayed, or conditioned screening or stabilizing care based upon my signing or refusing to sign this paragraph or based upon any payment related concerns.

10. Obligation to Pay My Hospital Bill. I acknowledge that I am financially responsible for my Hospital bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by my health insurance, and I agree to pay them promptly. If my insurance does not pay my claim after reasonable attempts by the Hospital, I may be responsible for paying my entire bill to the Hospital.

11. Financial Assistance. **I understand the Hospital has financial assistance programs available to those individuals who are unable to pay for their care, based upon a determination of financial need.** By signing below, I acknowledge that the Hospital's financial assistance policy is available to me on the Hospital's webpage or, will be made available to me upon request from the person who provided me this form. I understand I may be asked to provide my personal financial information and/or submit to a credit check in order to qualify for the financial assistance program. If I do not qualify for a financial assistance program, I understand that I may be able to enter into a payment plan with the Hospital.

12. Payment Contact. I authorize the Hospital, its service providers (including service providers contacting me about obtaining potential financial assistance for my account(s) and/ or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using prerecorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

13. Video Surveillance. I consent to video surveillance monitoring throughout the Hospital's facilities for safety purposes, which may include my private hospital room with appropriate notice.

14. Children born during Admission or Treatment. My consent to all of the elements set forth above, shall also apply to any child of mine who is born during admission or treatment at Hospital.

_____

Patient or Patient's Representative (if patient is minor or unable to sign) Date of Birth Relationship to Patient Date and Time

If patient is a minor, the parent must also complete the following:
The undersigned guarantees and agrees to pay to the Hospital on demand for any and all indebtedness of the patient to the Hospital relating to services provided pursuant to this consent form.

Guarantor Date and Time

_____
Guarantor (Print Name)

Patient Identification

Baptist Medical Group
Patient Consent and Responsibility Agreement

Welcome to Baptist Medical Group (BMG). We understand you have many choices when it comes to health care and we are glad you chose our medical group. We look forward to providing you with quality health care that is accessible, comprehensive, team-based, coordinated, and focused on your health and safety. Please review the following patient responsibilities, sign and return.

CONSENT FOR TREATMENT. I consent to all services as ordered or performed by my BMG physician, advanced practice provider, or their assistants and designees. This care may include, but is not limited to, medical examination and treatment, administration of drugs or vaccines, nursing care, laboratory, and x-ray procedures. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me about the results of any treatment.

OBLIGATION TO PAY MY BMG BILL: I understand that all charges for services rendered are due and payable at the time of service. If I have health care insurance, I agree to pay for any deductibles, co-payments and the patient responsibility portion of the fee at the time of service. I acknowledge that I am financially responsible for my provider bills (or, if signed by a guarantor, the guarantor is responsible) which are not paid for by a third party payor, and I agree to pay the bill promptly.

MEDICAL INSURANCE: I authorize BMG to bill my health plan or other applicable insurer or third party payor and I assign to BMG all of my rights and claims for reimbursement by a third party payor. I authorize BMG to release to all third party payors any medical information that is required in order for BMG to receive payment for its services to me. I will inform my provider of any changes in address or phone number for myself and/or responsible party, present my photo ID and all insurance identification cards upon request. I understand I may be responsible for the entire provider bill if my third party payor refuses to pay after reasonable attempts to collect from the third party payor.

APPOINTMENTS: I agree to bring a list of all medications I am currently taking to each appointment. I agree to check in on time for my appointment. I understand that if I am late for my appointment, I will be rescheduled for the next available appointment time and understand there may not be an appointment available the same day. I agree to notify the office at least 24 hours in advance of my appointment if I find I must cancel my appointment. I understand that failure to notify the office 24 hours in advance may result in a $25.00 missed appointment fee, which cannot be billed to insurance. I understand my patient/physician relationship may be terminated if I miss more than three appointments.

AUTHORIZATIONS AND REFERRALS: I understand that I am responsible for notifying the practice if my third party payor requires pre-authorizations for tests or for referrals to specialists. I understand the BMG office staff may assist me with scheduling referrals or diagnostic testing, but failure to obtain necessary authorizations before the scheduled appointment may result in the visit/test needing to be rescheduled and/or charges being billed directly to me.

FINANCIAL ASSISTANCE: I understand there are financial assistance programs available for patients who are unable to pay for their care based upon a determination of financial need in accordance with Baptist Health Care's Financial Assistance Policy. I understand it is my responsibility to contact a Patient Account Specialist at BMG's business office at (850) 469-2000 to request financial assistance or access the policy and application at https://ebaptisthealthcare.org/PatientFinancialResources. I agree to provide my personal financial information and/or submit to a credit check to determine if I qualify for financial assistance. If I do not qualify for financial assistance and do not have insurance third party payor, I understand and agree that I will pay in full for all services at the time of service. If I do not have insurance, I may be eligible for a discount when full payment is made at time of service.

RETURN CHECK POLICY: I understand I will be responsible for all service charges and collection fees associated with collecting any bad check I write, and will pay these fees upon notice.

BUSINESS HOURS: I understand unusual circumstances will sometimes require the office hours to be changed without notice. I understand the pre-recorded telephone message will let me know when to call back for routine requests and what to do in case of an urgent medical need (one that does not require emergency treatment). I understand that I should call 911 in the event of a medical emergency or proceed to the closest emergency room for treatment.

PRESCRIPTIONS AND/OR REFILLS: I understand that requests for new medication and/or refills should be made during my visit with my provider. If I need a prescription refill between visits, I agree to contact the practice or my pharmacy and allow 48 to 72 business hours to process. I understand refill requests will only be processed during office hours. I understand that narcotic prescriptions are highly regulated and may require a signed narcotics agreement between me and my provider.

PATIENT FORMS COMPLETION: I understand that an office visit may be necessary if I request the provider complete certain forms for me. There may also be a nominal fee, payable in advance, for the completion of these forms. I understand these requests may take up to 14 days for processing.

PATIENT PORTAL: I understand this practice may have a patient portal to offer me a secure online website for convenient 24-hour access to my personal health information. This is an optional program using a secure username and password. Recent doctor visit notes, medications, contact information and health records can be viewed and printed. The office staff can provide more information regarding the patient portal which may be accessed at https://ebaptisthealthcare.org/PatientPortal.

WIRELESS COMMUNICATION: By providing a wireless or mobile telephone number, I give permission to my provider to use this number for contact. Contact includes receiving calls and messages, including pre-recorded messages and calls via an automatic telephone dialer from the practice and its authorized agents.

NOTICE OF PRIVACY PRACTICES: I understand that Baptist Health Care's Notice of Privacy Practices provides information about how my health information may be used and disclosed. I have been offered and (if requested by me) received a copy of the Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND CONSENT TO TREATMENT BY BMG AND I AGREE TO ABIDE BY THE ABOVE PATIENT RESPONSIBILITIES.

Patient/Personal Representative Signature	**Date**
Print Patient/Personal Representative Name	**Personal Representative's relationship to patient:**

PATIENT REGISTRATION FORM

PATIENT INFORMATION: THIS SECTION REFERS TO THE PATIENT ONLY

Last Name: _____ First Name: _____ MI: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Date of Birth: _____ **Sex:** M F **Marital Status:** Married Single Divorced Widowed **Preferred Language:** _____

Race: ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Unknown/Declined to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Declined to answer

Home phone: (_____)_____ cell phone: (_____)_____ work phone: (_____)_____

Best daytime number to reach you: ☐ home ☐ work ☐ cell Is it ok to leave a message at any of the numbers? ☐ Yes ☐ No

If no, please designate which ones, if any: _____

Primary Care Physician's Name (if applicable): _____ How did you hear about us? _____

Spouse's Name: _____ Date of Birth: _____ Spouse's SS#: _____

RESPONSIBLE PARTY: THIS SECTION REFERS TO THE PERSON/PARTY WHO SHOULD RECEIVE THE BILL

Relationship to Patient: ☐ Self (skip to next section) ☐ Parent ☐ Spouse ☐ Other (skip to next section) _____

Last Name: _____ First Name: _____ MI: _____

Social Security Number: _____ Birth date (mm/dd/yyyy): _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

INSURANCE INFORMATION

Primary Insurance Coverage: _____ Copay: $_____

Policy effective date: _____ Deductible: $_____ Met? ☐ Yes ☐ No If no, amount met: $ _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Secondary Insurance Coverage: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Subscriber: _____

Subscriber's DOB: _____ Subscriber's SS #: _____

Communication with Family Members and Friends Involved In Patient Care

This form documents my request to allow family members and/or friends to be involved in relevant ***verbal discussions*** regarding my health care. By signing this form, I permit Baptist Medical Group ("BMG") staff to discuss information about me with the people listed below. This information may include diagnoses, test results, treatments, and payment information, but shall be limited to only the information that, in the professional judgment of your provider, needs to be shared.

- I understand that signing this form is voluntary and that I am not required to sign this form in order to receive health care.
- I understand that information may be released to family members or others without this form, if allowed by federal and state law.
- I understand that listing a person on this form does not give them the right to receive or copy my written medical records. It does not allow them to consent for health care services on my behalf.
- I understand that my health care provider will discuss only the information that the person involved needs to know about my care or treatment.
- I can update this form at any time by completing a new form and giving it to BMG staff.
- I understand that BMG staff will verify the identity of the people below (if not known to the staff) prior to discussing this information.
- **I understand that this is *not* a Health Insurance Portability and Accountability Act (HIPAA) authorization form that would allow the people below to have access to my written Protected Health Information.**

Name:	*Phone #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*
Name:	*Phone #:*	*Relationship:*

Signature: _____

Print Name: _____

Date: _____ Time:_____

Relationship to Patient:
□ Self
□ Legal Representative or Guardian (*proof of power of attorney or legal guardianship required*)

DISCLOSURE TO FAMILIES AND LOVED ONES (Emergency Contacts)

I authorize Baptist Medical Group, to disclose my health care information and to discuss my health care needs to those that I designate. I further authorize the release of my billing information and give these individuals the ability to pick up prescriptions and/or medications on my behalf. A photo ID is required for prescription pickup. These individuals will be considered my emergency contacts. Without authorization, no information may be shared. I authorize Baptist Medical Group to disclose my personal health information to the following people:

Name: _____ Relationship: _____ Phone: (_____)_____

Name: _____ Relationship: _____ Phone: (_____)_____

Name: _____ Relationship: _____ Phone: (_____)_____

CONSENT TO TREATMENT FOR ALL PATIENTS

I hereby grant authorization and consent for medical treatment and/or procedures for myself or the patient for whom I am the parent or legally authorized representative for which I am signing for, and understand that no guarantee or assurance has been made as to the results for which may be obtained. I agree to allow my provider to access all of my medication history including medications prescribed by other providers.

_____
Patient initials

PHOTO DOCUMENTATION

I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

_____
Patient initials

NOTICE OF PRIVACY PRACTICES

I received a copy of the Baptist Health Care "Notice of Privacy Practices" today and agree with these privacy policies.

_____
Patient initials

INSURANCE ASSIGNMENT AND FINANCIAL RESPONSIBILITY

I hereby authorize the offices of Baptist Medical Group (BMG), to release any medical information required during the course of examination and treatment to my insurance company, and I permit payment to BMG from my insurance for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services.

I understand that I am responsible for all charges incurred regardless of the insurance status. I agree to pay for services incurred after the patient has been charged for the office visit, such as labs, radiology, medical supplies, etc. I agree to pay my bill in full for services rendered by Baptist Medical Group providers.

_____
Patient initials

_____ _____

Date **Signature of Patient or Guardian if patient is Minor**

Patient Name: _____ DOB: _____

PATIENT HISTORY FORM

Place a check √ beside any medical problem (s) you have had in the past or may currently have and include year if known.
Place a check √ beside any medical problem (s) any family member has had in the past or may currently have and list relationship using key: **Maternal/Paternal M – Mother; Maternal/Paternal F – Father; Maternal/Paternal GM – Grandmother; Maternal/Paternal GF - Grandfather**

PATIENT AND FAMILY

	Patient	Year	Family		Patient	Year	Family
Anemia				Immune Deficiency			
Arthritis				Liver Disease			
Heart Arrhythmia/Palpitations				Kidney Disease			
Asthma				Neuropathy			
Bleeding Problems				Paralysis			
Blood Clots				Peripheral Vascular Disease			
Cancer: Type _____				Pneumonia			
Chest Pain/Angina				Psychiatric Illness			
Diabetes				Pulmonary Embolism			
Gall Bladder disease				Reflux			
Gastric Ulcers				Skin ulcer/breakdown			
Glaucoma / Loss of Vision				Steroid Use			
Heart Attack				Stroke			
Heart Failure				Thyroid Disease			
Heart Murmur				Tuberculosis (TB)			
Hepatitis B / Hepatitis C				Urinary Infections			
High Blood Pressure				Valve Disorders (Heart)			
HIV/AIDS				Wound Healing Problems			

List any medical problem(s) not listed above: _____

Are you experiencing any of the above problem(s) today? Yes ☐ No ☐ If Yes, when did symptoms begin? _____
If you checked yes, please explain: _____
_____
_____

Have you had a pneumonia shot? Yes ☐ No ☐ If yes, when: _____ When was your last flu shot? _____

Please check √ if you have any allergies: Yes ☐ No ☐ If yes, please list: _____
_____

Please check √ if you have any medication allergies: Yes ☐ No ☐ If yes, please list: _____
_____

Please list current medication(s) below:
_____ Dosage _____ Physician _____
_____ Dosage _____ Physician _____
_____ Dosage _____ Physician _____
_____ Dosage _____ Physician _____
_____ Dosage _____ Physician _____
_____ Dosage _____ Physician _____

Please list any surgeries and/or hospitalizations you have had below and, if possible, physician(s) and date (s). (Continue on back if needed)
_____ Physician: _____ Date: _____
_____ Physician: _____ Date: _____
_____ Physician: _____ Date: _____

Social History

Alcohol? Yes ☐ No ☐ If yes, drinks per week: _____ Smoking/Tobacco? Yes ☐ No ☐ If yes, Packs/day: _____ Years _____

History of Illicit Drug Abuse? Yes ☐ No ☐ If yes, kind(s) of drug: _____ Frequency: _____

Smokeless Tobacco? Yes ☐ No ☐ Frequency: _____ Daily caffeine intake (coffee, tea, sodas)? _____

Patient Signature: _____ Date: _____
Provider Signature: _____ Date: _____

NAME: _____ **DOB:** _____

Number of pregnancies: _____ Number of children born live: _____
Number of pregnancy terminations: _____ Number of living children: _____
Number of miscarriages: _____

Pregnancy Record										
No.	Born Mo/Yr	Name	Birth Weight	Sex	Weeks PG	Hrs in Labor	Type of Delivery	Anesthesia	Hospital	Comments / Complications
				M F						
				M F						
				M F						
				M F						
				M F						
				M F						

If you are still having menstrual cycles, please check the following that apply:

☐ Regular ☐ Infrequent ☐ Too heavy ☐ Irregular

☐ Too frequent ☐ Too light ☐ Painful

Date of last menstrual period: _____ Date of last pap smear: _____

Present method of birth control:

☐ None ☐ Vasectomy ☐ Birth Control Pills ☐ Suppositories ☐ Tubal Ligation ☐ IUD

☐ Foam ☐ Condoms ☐ Rhythm ☐ Depo Provera ☐ Norplant ☐ Diaphragm

___ BMP-Pensacola (Family Practice)
___ BMP-Pensacola (Occ Med/Walk In Care)
___ BMP-Navarre
___ Gulf Breeze MOB
___ Pace
___ Perdido
___ Oncology
___ Ortho Trauma
___ Urology
___ Vascular Surgery
___ North Hill Internal Medicine
___ Rheumatology
_X_ L:adies First OB/Gyn
___ Other _____

Authorization for Release of Protected Health Information

Patient Name: _____
(Last) **(First)** **(Middle)**

SS#: _____ **Date of Birth:** _____ **Telephone #:** _____ **MR#:**_____

1. I hereby authorize the following person(s) / entity:

_____
(Name of Entity/Individual/Class of Persons)

_____
(Address)

_____
(City/State/Zip)

_____ _____
Phone Fax

To release to:

Baptist Medical Group – Ladies First OB/Gyn
Tracey Thomas-Doyle, MD
Erika Schneider, MD
Leslie Sanders, MD; W. Marc Boyd, D.O., M.D.
Michelle Spinner, ARNP ~ Connie Killam, ARNP
3417 N. 12th Ave., Pensacola, FL 32503
(850) 432-7310 (phone)
(850) 432-7320 (fax)

2. I authorize the following types of information to be released:
☐ General Medical ☐ HIV/AIDS (May not apply to Labs) ☐ Substance Abuse ☐ Psychiatric ☐ Psychotherapy Notes

3. I authorize the following types of records to be released: (check all that apply)
☐ General Abstract (includes Face Sheet, Discharge Summary, History & Physical, Operative Report, Pathology, and Consultation Reports)
☐ Face Sheet ☐ Pathology ☐ Cardiology Reports ☐ Other: (please specify below)
☐ Discharge Summary ☐ Consultations ☐ Radiology Reports
☐ History & Physical ☐ Labs ☐ Radiology Film _____
☐ Operative Report ☐ ER Record (Type: _____)

4. I authorize the following date(s) of service to be released: _____

5. This information is needed for the following purpose(s):
☐ Continued Care ☐ Insurance Claim ☐ Other: _____
☐ Personal Use ☐ Legal Purposes

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Facility Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
_____.
If I fail to specify an expiration date, event, or condition, the authorization will expire within **12 months**.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal or State Privacy Laws. If I have questions about disclosure of my protected health information, I can contact the BHC Privacy Officer at (850) 434-4472. I also understand that obtaining medical information under false pretenses is a Federal and State crime, punishable by up to 10 years in prison.

8. If present, alcohol and drug abuse information has been disclosed from records whose confidentiality is protected by Federal law. Federal regulations 42CFR, Part2, prohibit making any further disclosure of records without the specific written authorization of the person to whom it pertains or as otherwise permitted by law.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

BAPTIST HEALTH CARE - CONSENT FOR PELVIC EXAMINATION

(To be used in the inpatient, outpatient, and ambulatory setting)

I understand that Florida law requires my written consent for a pelvic examination. I consent to undergo pelvic examinations, as described herein, as part of my care and treatment.

I understand that a pelvic examination means a manual examination of the organs of the female reproductive system using a gloved hand or instrumentation (the "Examination").

I understand that the Examination, or portions of it, may be performed by physicians, nurses, nurse midwives, nurse practitioners, or physician assistants (hereafter referred to as, "health care practitioners").

I understand that medical students or any other student receiving training as a health care practitioner (hereinafter referred to as a "student" or "students") may also participate in the Examination as part of my care and treatment.

I understand if I am a pregnant woman having contractions, this consent will cover my initial Examination and any subsequent pelvic examinations that may be conducted during the course of my care and treatment at this facility.

I understand that the health care practitioner who will perform or oversee the Examination will inform me of the purpose and scope of the exam and will answer any questions that I have regarding the Examination. My health care practitioner has explained the process of the Examination to me, including information on why the Examination is a necessary part of my care and any risks associated with the Examination. I have also had the opportunity to raise any concerns I may have about receiving the Examination, including any risks associated with refusing the Examination and alternatives to the Examination.

I have also given my informed verbal consent to such Examination.

I understand that I may revoke this consent at any time. Unless revoked by me, this consent will remain in effect during a recurrent course of care.

By signing this consent, I acknowledge that I have read this consent form (or had it read to me) and I understand that I am consenting to the Examination(s) per my selection below. I have had the opportunity to ask any questions and my questions have been answered to my satisfaction.

☐ **I AGREE AND CONSENT** to an Examination performed by a health care practitioner or a student with direct supervision by a health care practitioner.

☐ **I REFUSE CONSENT** for an Examination performed by a student **AND ONLY AGREE AND CONSENT** to the performance of an Examination by a health care practitioner.

_____

Patient or Patient's Representative (if patient is a minor or unable to sign)

_____

Patient's Date of Birth | Relationship to Patient | Date and Time

Patient Identification