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## Health Care Status Authorization

I, \_\_\_\_\_ (Name of patient), hereby give authorization to Baptist Primary Care for the release of information concerning the status of my health care, including results of laboratory and radiology tests and to discuss my plan of treatment with:

\_\_\_\_\_  
Name of Authorized Individual

\_\_\_\_\_  
Relationship to Patient

I understand that I may revoke this authorization at any time.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## Authorization for Use of Answering Machines

I, \_\_\_\_\_ (Name of patient), authorize Baptist Primary Care to provide detailed information to me via my home and/or work answering machine or cell phone voice mail concerning appointment, referral and test information. I understand that I may revoke this authorization at any time.

\_\_\_\_\_  
Patient (Parent) Signature

\_\_\_\_\_  
Date