Florida Neurosurgery and Spine DBA

PATIENT DEMOGRAPHICS

First Name: ______________________________ Middle Initial: ___ Legal Last Name: ___________________

Marital Status: ______________Date of Birth: _____________SSN#: _________________ Gender: [_]M [_]F

Home Address:____

City: _______________________________ State: _____ Zip Code: _________ Home Phone: _____________

Cell Phone: ____________________ Email: _____________________________

EMERGENCY CONTACT

Name: ___________________________ Phone #:_______________ Relationship: ____________

Race (Circle one or mark one)

Caucasian, African American,

Native American or Native Alaskan,

Native Hawaiian or Pacific Islander,

Asian, Multiracial, Other:______________

[_] I prefer not to identify my race

Ethnicity (Circle one or mark one)

Non-Hispanic, Hispanic/Latino,

Middle Eastern, Central American,

Italian, Korean, Japanese, Chinese

Other:_________________

[_] I prefer not to identify my ethnicity

Preferred Pharmacy

Name of Pharmacy: ___________________Address: ___________________________ Zip code: _______

(Prescriptions from Dr. Johnson cannot be filled at Walmart or Sam's Club, they have him listed as an incorrect specialty)

Authorization to Release Appointment/Financial Information

Due to the HIPAA Privacy Act, we CANNOT give out any information or leave messages for you without your consent. If there is a person you would like to authorize to speak with our office on your behalf about appointment, should you not be available please list them below with the requested information to verify identity (list full legal name on their ID):

Name: __________________________ Relationship to you:________________ Phone#:_________________

Name: __________________________ Relationship to you:________________ Phone#:_________________

I currently reside in a nursing/retirement home? [_] Yes [_] No If yes, which one? ______________________

If yes, are the staff of Florida Neurosurgery and Spine Center PA authorized to provide the nursing home/retirement home you currently reside at, with your appointment time and date if they call on your behalf. [_] Yes [_] No

INSURANCE INFORMATION

It is all the patient 's responsibility to keep the office up to date with insurance changes. Patients are responsible for knowing their own plans, resolving their Coordination of Benefit Issues and resolving any Name/date of birth discrepancies reported to themselves or to the office. If insurance reports to the office a patient is in their Grace Period the patient must contact their insurance to address the matter. The office will not allow patients to be seen if a patient's insurance is reporting the patient in a Grace Period. If prior authorization is required from the patient's primary care provider it is the patient's responsibility to contact their primary care providers office to request authorization to be sent to this office. Patients must have active coverage that is verified by their insurance carrier, or the patient will have to pay the upfront self pay rate for their appointment prior to treatment. All copays, co-insurances, and deductibles must be collected prior to services rendered, or patient appointments will be canceled or rescheduled. The office gathers an estimate from all patient's active insurance which the office will request the patient to pay. Patients with out of network insurance and no out of network benefits must pay the self pay rate.

(Please make sure to give your ID & insurance cards to the front desk- the office must have a copy on file)

Are you being seen by your providers due to an Injury Involving:

Work? YES or NO (circle one) If yes, what is the date of injury? _______________
Auto Accident? YES or NO (circle one) If yes, what is the date of the accident? __________
Other Claim? YES or NO (circle one) If yes, what is the date of injury? _______________

Liability Carrier: ______________________________________ Claim #:_________________________
State Accident In:_____ Injuries From Accident:____
Adjuster Name: _______________________ Phone #:________________ Email: ____________________

Health Insurance Coverage

Primary Ins.: _______________________________ Policy/Member ID:__________________________

Policy Holder/Subscriber Name: __________________________________ DOB: _________________

Secondary Ins.: ______________________________ Policy/Member ID:__________________________

Policy Holder/Subscriber Name: __________________________________ DOB: _________________

Tertiary Ins.: _______________________________ Policy/Member ID: __________________________

Policy Holder/Subscriber Name: ___________________________________ DOB: _________________

The information I have provided on Page 1 and Page 2 is true to the best of my knowledge.

Patient/Patient Representative Signature: _________________________________ Date: _____________

PATIENT HISTORY

SOCIAL & MEDICAL HISTORY

Have you had recent or persistent problems with the following? (Check and/or fill in all that apply)

Do you smoke/chew tobacco?
❑Yes
❑No
❑I have never smoked/chewed tobacco
If yes, how many packs a day? ______
How long have you smoked?______ years

Do you drink alcohol?
❑Yes
❑No
❑I have never drank alcohol
If yes, how often? ______/week

Chronic or Communicable Disease?
❑Yes
❑No
If yes, which:
❑HIV ❑Hepatitis ❑Other: ______

Are you a former smoker?
❑Yes
❑No If yes, when was the date you quit: ________

Marital Status:
❑Single
❑Married
❑Divorced
❑Widowed

Recreational or Non Prescribed drug use?
❑Yes
❑No
If yes, which:
❑IV Drug
❑CBD
❑Marijuana/THC
❑Other: ________

Prior diagnosis of Cancer? If yes, type & when? ____

Allergies To Medications (and/or other Allergies):____

Have you had any pregnancies? ❑Yes ❑No ❑N/A- I am a male
Are you pregnant or breastfeeding now? ❑Yes ❑No ❑N/A- I am a male
How many children do you have? ____ Male children ____Female children

IMMUNIZATIONS (Last Date of)
Tetanus Shot: _____/_____/_____ Flu Shot: _____/_____/_____ Pneumonia Shot: ____/_____/_____

CURRENT MEDICATIONS LIST: Medication & Dosage (Request Med List Sheet if needed)

Med________________Dosage__________ Med________________Dosage___________
Med________________Dosage__________ Med________________Dosage___________
Med________________Dosage__________ Med_________________Dosage__________
❑ I am PRESCRIBED medical Marijuana/THC (please bring your card to office)

Implants/Medical Devices/Surgical & Hospital Admissions History
(Do you have any implanted medical devices, such as a pacemaker, pain pump, plates, etc. Please list them below)

Device: __________________ Date: ________ Device: __________________ Date: _______
Surgery: _________________ Date: ________ Surgery: _________________ Date: ________
Surgery: _________________ Date: ________ Surgery: _________________ Date: ________

PREVIOUS HISTORY AND/OR PERSISTENT PROBLEMS (Check all that apply)

Cardiovascular:
❏ Arrhythmia/Atrial Fibrillation ❏ Congestive Heart Failure ❏ Hypertension ❏ Rheumatic Fever

Mouth:
❏ Dentures ❏ Hoarseness ❏ Gums ❏ Last Dental Exam: ____________________

Lungs:
❏ Hyper-cholesterol ❏ Myocardial Infarction ❏ Coronary Artery Disease ❏ Valvular Heart Disease
❏ Peripheral Vascular Disease ❏ Carotid Artery Stenosis ❏ Aneurysm _____________________

Neurological:
❏ Stroke/ TIA ❏ Seizures ❏ Peripheral Neuropathy ❏ TBI/Concussion/SDH/SAH ❏ Parkinson's
❏ Alzheimer's/Dementia ❏ Guillain Barre ❏ Multiple Sclerosis 3

Genitourinary/Gastrointestinal:
❏ BPH ❏ Kidney Disease/Failure ❏ Kidney Stones ❏ Recurrent UTI ❏ Cirrhosis
❏ Gallbladder/Gallstones ❏ Irritable Bowel Syndrome ❏ Reflux/GERD ❏ Crohn's/UC
❏ Gastric Ulcer

Pulm:
❏ Asthma ❏ COPD ❏ Sleep Apnea/CPAP ❏ Pulmonary Embolism ❏Other _________________

Ophthalmology:
❏ Blindness ❏ Macular Degeneration ❏ Cataracts ❏ Glaucoma ❏ Detached Retina

Orthopedics:
❏ Osteoarthritis ❏ Degenerative Joint Disease ❏ Osteoporosis/compression FX ❏ Gout

Endo:
❏ Diabetes ❏ Thyroid ❏ Obesity

Infectious Disease:
❏ HIV/AIDS ❏ Hx MRSA ❏ Hepatitis ❏ Lyme Disease

Psychiatric:
❏ Anxiety/Depression ❏ Bipolar ❏ Schizophrenia ❏ Autism/Asperger's

Hematology/Oncology:
❏ Clotting Disorder ❏ Sickle Cell ❏ Anemia ❏ Deep Vein Thrombosis ❏ Cancer

Rheumatology:
❏ Lupus ❏ Ankylosing Arthritis

Women (Only):
❏Polycystic Ovarian Syndrome ❏Endometriosis

Patient Signature: ___________________________________ Date: _______________

CURRENT REVIEW OF SYSTEMS : Please mark all that apply for today.

What Symptoms are you feeling TODAY?

None Apply _____

General
- ☐Fever ☐Night Sweats
- ☐Chills ☐ Fatigue
- ☐Weight Loss ☐Weight Gain

Eyes
- ☐Double Vision ☐Vision Loss
- ☐Photopsia(flashes) ☐Floaters in Eye
- ☐Worsening Vision ☐Blurry Vision
- ☐Pain with Movement in the Eye(s)

Ears
- ☐Dizziness ☐Drainage
- ☐Ear Pain ☐Hearing Loss
- ☐Ringing in Ears

Throat
- ☐Hoarseness ☐Difficulty Swallowing
- ☐Throat Pain ☐Recurrent Sore Throat

Allergy
- ☐Itchy Nose ☐Itchy Eyes

Respiratory
- ☐Snoring ☐Wet Cough
- ☐Dry Cough ☐ Coughing up phlegm
- ☐Wheezing ☐Shortness of breath

Alerts:
- ☐Pregnant(weeks:__) ☐Breastfeeding

Cardiac
- ☐Chest Pain ☐Irregular Heartbeats
- ☐Defibrillator ☐ Pacemaker
- ☐Blood Thinners

Gastrointestinal
- ☐Heartburn ☐Diarrhea
- ☐Nausea ☐ Constipation
- ☐Vomiting ☐Blood in Stool

GU
- ☐Difficulty urinating ☐Blood in Urine
- ☐Frequency/Urgency ☐ Pain Urinating
- ☐Burning Urination ☐Lower back pain
- ☐Recurrent UTI's

Endocrine
- ☐Heat Intolerance ☐Cold Intolerance

Neurologic
- ☐Headaches ☐Seizure
- ☐Migraines ☐Numbness/Tingling

Musculoskeletal
- ☐Joint Pain ☐Non healing wounds

Psych
- ☐Anxiety ☐Depression

Dermatology
- ☐Itching ☐Rash ☐Dry Skin

Family History: Has anyone in your family had the following? Indicate what family member had the following Mom (M), Dad (D), Grandparents (G), Sister (S), Brother (B), Children ©

❑ Arthritis: ________________	❑ Diabetes: ___________________	❑ Asthma _______________
❑ Epilepsy/Seizures __________	❑ High Cholesterol _____________	❑ Mental Illness __________
❑ Had a Stroke ______________	❑High Blood Pressure __________	❑ Cancer ________________
❑ Tuberculosis ______________		

Patient Signature: ____________________________________ Date: _______________

ASSIGNMENT OF BENEFITS

I, ___________________________________, hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to, to Florida Neurosurgery and Spine Center PA, my medical provider. I hereby instruct the insurance/liability insurance carrier to pay Florida Neurosurgery and Spine Center PA directly any monies due you for medical services you rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance and to pay my copays, coinsurance, deductibles and any out of pocket cost my insurance directs as my responsibility. I authorize and consent to Florida Neurosurgery and Spine Center PA acting on my behalf in this regard and in regard to my general health insurance coverage and I especially authorize you to pursue any administrative appeals conducted pursuant to ERISA, including but not limited to the authority to request and/or receive applicable Plan Documents. In the event the insurance carrier responsible for making medical payments in this matter doesn't accept my assignment, or my assignment is challenged or deemed invalid, I authorize Florida Neurosurgery and Spine Center PA's collections attorney as my agent and attorney to collect payment for your medical services directly against the carrier in this case, in my name, including filing an arbitration demand or lawsuit. I specifically authorize that attorney to file directly against that carrier in my name or in Florida Neurosurgery and Spine Center PA's name as a medical provider rendering services to me and designate Florida Neurosurgery and Spine Center PA's collection attorney as my attorney-in-fact. I authorize Florida Neurosurgery and Spine Center PA and the practice's attorney to receive from my insurer, immediately upon verbal request, all information regarding the last payment made by said insurer on my claim, including date of payment and balance of benefits remaining. I authorize Florida Neurosurgery and Spine Center PA and the practice's attorney to obtain medical information regarding my physical condition from any other health care provider, including hospitals, diagnostic centers, etc., and I especially authorize such health care provider(s) to release such information to Florida Neurosurgery and Spine Center PA about me, including medical reports, X-ray reports, narrative reports, and any other report or information regarding my physical condition.

_______________________________________ _________________

Patient Name Patient Date of Birth

_______________________________________ _________________

Signature of the Patient/Patient Representative Date Signed

AUTHORIZATION TO RELEASE INFORMATION

I authorize Florida Neurosurgery and Spine Center PA to release any information necessary to insurance carriers regarding my illness, diagnosis, and treatments, process insurance claims generated in the course of examination and/or treatment, and allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by myself in writing. I authorize Florida Neurosurgery and Spine Center PA and providing physicians to disclose all or any part of my patient record to any person or corporation which is or may be liable under contract to this practice, myself or a family member of mine, for all or part of this practice's charges, including but not limited to, hospital or medical service companies, insurance companies, Workers Compensation carriers, welfare agencies, or my employer, provided such release of information shall be in accordance with state and federal laws and regulations. A photocopy of this assignment is to be considered as valid as the original.

_______________________________________ _________________

Patient Name Patient Date of Birth

_______________________________________ _________________

Signature of the Patient/Patient Representative Date Signed

PRACTICE POLICIES

PRIVATE AND PATIENT INFORMATION

All private and patient information and documentation will only be used in the way authorized and described and allowed to be used by state and federal laws. Only authorized personnel have access to private information. All private and confidential health care information is stored and kept under HIPAA compliant regulation storage and protective systems. A signed release of information from the patient must be complete prior to the office being able to provide a copy of their records maintained and created by Florida Neurosurgery and Spine Center, PA. Our office is HIPAA compliant and must have patient written consent on file prior to releasing records to themselves or another person/medical office. Florida Neurosurgery and Spine Center PA can not and will not be able to provide a copy of other medical office/facility records to patients they may have received pertaining to continuation of care and referrals, any records a patient may want/request must be obtained from the original creating source.

AUTHORIZATIONS & REFERRAL

If the office does not have an active authorization and/or referral on file, your appointment is subject to being canceled and/or rescheduled. It is the patient's responsibility to make sure there is an active Authorization or an active Referral to our office if your insurance plan requires it. We are only able to get an estimate from insurance on the patient copay/co-ins/ded. to collect, any patient responsibility not collected at time of service will be billed to the patient. If you are in your Grace Period with your insurance carrier, your appointment will be canceled until you are no longer in your Grace Period.

SERVICES

Each provider may have additional forms to complete for their specialty type and services they provide and offer. All state and federal regulations must be followed and patients must comply with compliance regulation, which may be completing urine testing and/or forms and agreements if requested by the physician, we must keep on file.

RETURNED CHECK FEE

I, the patient, acknowledge a fee of $50 for any returned checks. In order for Florida Neurosurgery and Spine Center PA to service your account or to collect monies I may owe, Florida Neurosurgery and Spine Center PA and/or agents may contact me by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to me. Florida Neurosurgery and Spine Center PA may also contact you by sending text messages or emails, using any email addresses you provide to use. Methods of contact may include using pre recorded/artificial voice messages and/or use of automatic dialing services as applicable. I have read this disclosure and agree that The Florida Neurosurgery and Spine Center PA employees and/or agents may contact me/us as described above.

COLLECTION PROCESS

By signing below, I understand and authorize Florida Neurosurgery and Spine Center PA to send any outstanding balances for services rendered to me past 90 days to a collections agency to collect the owed balance on their behalf. In the event that an account is referred to an outside collection agency and/or small claims suit, that responsible party will be subject to paying any/all fees associated with the collection processes. I, the patient, hereby authorize Florida Neurosurgery and Spine Center PA to obtain a credit history for such collection purposes. In the event the office must commence legal action against myself, the patient, for payment of my balance, I agree to be liable for attorney fees and costs incurred by the office as part of such action and any attorney fees and costs incurred by this office in order to recover on the resulting judgment.

____
Initial Here

MEDICARE: (for Medicare patients only)

I, ______________________________, certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize all medical records to be released to the Social Security Administration or its intermediaries or carriers and request that payment of authorized benefits be made on my behalf and I assign the benefits payable for physician service to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Patient/Patient Representative Signature: ______________________________________ Date: ____________

AUTHORIZATION FOR MEDICAL CARE AND TREATMENT:

1. I recognize that a medical condition may exist requiring medical care and I voluntarily consent to such medical care, treatment and diagnostic procedures by Florida Neurosurgery and Spine Center PA and its medical and professional staff, associates and agents as deemed necessary.
2. I hereby authorize my physician, as provided by law to furnish medical treatment, diagnostic procedures, x-ray/MRI diagnosis or therapy as he/she considers necessary and proper in the treatment process.
3. I am aware that the practice of medicine and surgery, and the administration of medical care, are not exact sciences and I acknowledge that no guarantees have been made to me as to the result of diagnostic procedures, treatments, examinations or care undertaken with Florida Neurosurgery and Spine Center PA.

CANCELLATION/ATTENDANCE POLICY

Florida Neurosurgery and Spine Center PA discourage cancellations, however we do understand that emergency situations can arise. Patients must call at least 24 hours in advance to cancel their appointment, or a no show/late/cancellation fee will apply.

If 24 hours advance notice is not given or the patient does not show up for a scheduled appointment, there will be a charge. If you are more than 15 minutes late for your appointment, you may not be seen and the same day cancellation fee may apply.

- First attendance offense fee is $75.00
- Second attendance offense is $100.00
- Third attendance offense if $150.00
- Emergency appointment due to last minute patient cancelation/no-show emergency scheduling fee of $50.00
- Walk-in without appointment is subject to provider availability and a $150.00 fee may apply if interrupting clinic (Please do not show up without an appointment. Patients are encouraged to call prior and leave message if no answer)
- No Show/Late/Same Day Cancelation Fee for procedures and Surgeries (without 1 week notice) is $150.00
- Repetitive Cancellations/Rescheduling may result in patient discharge

By signing below I acknowledge I have read, understand and agree to all the above and will comply with these office policies and fees.

Patient/Patient Representative Signature: ____ Date: ____________

____
Initial Here

AFTER SURGERY

For all patients who continue to have pain following surgery or have a condition that requires ongoing pain medication, the office has a consulting service to help with chronic pain. Chronic pain management patients will be referred to this service, or referred out.

PAIN MEDICATION AFTER SURGERY

Pain medication may be prescribed to help control pain for the next 7 to 10 days following surgery or for an acute painful condition. After 10 days, the dosage of narcotics will typically be decreased over a 2 to 4 week period. You will then be placed on non-narcotics such as anti-inflammatory medication when appropriate. This treatment period will be discussed at your follow up visit.

MEDICATION & REFILLS

Medication is expected to be taken exactly as it is prescribed. In the event that a patient runs out of medication early, the office will not be able to refill the prescription unless your doctor or physician's assistant examines you. The office will not re-write prescriptions for pain medication that are lost, stolen, destroyed, or misplaced. To get a prescription refill, please call the main office at (850) 353-2055 during office hours. Due to the high volume of patients calls & requests, as well as our doctors' surgical/procedure schedule, please allow **48 to 72 business hours**, excluding holidays and weekends to process the request. Once the refill request is processed, you will receive a call/text/email. Please check with your pharmacy before calling the office to check the status of a refill request.

<u>Pharmacy out of medication prescribed</u>: It is the patient's responsibility to call other pharmacies to check if they have a medication on hand to fill the patient's prescription. Please call, leave a voice message, or email us with an update to where to send your prescription if your original pharmacy is out.

There will be an administrative fee of $25.00 for any medication refill requests made outside of regular scheduled appointments. This fee will need to be collected prior to having your RX called into your pharmacy. This policy will not apply toward Workers Compensation patients unless it is a medication that you need to pick up at the office. This policy will also not apply to patients who are less than 3 weeks post operation.

CONTINUATION OF CARE

In order to provide the best patient care we can, if a patient has not been seen in our clinic in the last three years the patient will need to complete the new patient paperwork as many symptoms may have changed since the last time they were seen. In addition, the provider the patient previously had care with may no longer be at the practice. The office will make every effort to get the patient seen by a provider that can treat the patients current needs.

My signature below means I have read, understood and agreed to comply with the office policies above.

Patient/Patient Representative Signature:____________________________ Date: ______________

____
Initial Here

SICK POLICY

The office encourages sick patients to stay home, however some medications and appointments we understand must be completed in office. We ask all patients that decide to come into the office sick, wear a mask. If a patient has tested positive for a contagious illness patients should not come into the office. Please contact the office via phone to update us of your upcoming appointment and situation so the provider can create a plan on how to best address the appointment and patient needs.

INSURANCE AND SELF PAY POLICY

It is the office policy that a patient's insurance presented and added on file is always billed. HOWEVER the office does not take/see patients with “Limited insurance plans”. The self pay rate is ONLY allow in the following situations:

- Patient does not have active insurance coverage
- Patient insurance is out of network and the patient does not have out of network benefits
- Patient insurance does not cover service/product rendered/ordered
- Patient insurance has denied authorization of service/product ordered and patient elects to self pay.
- Patient primary insurance is Auto Insurance and patient does not have health insurance, self pay must be collected due to no guarantee of payment and no ability to verify remaining PIP/Med pay benefits

OVERPAYMENTS, CREDITS & REFUNDS

Overpayments & refunds are made once a month by management. Credits on patient accounts will be applied to any past due balances prior to any remaining credit being refunded, if any remains. Credits can also be used towards co-pays and out of patient responsibilities on upcoming appointments as well.

HIPAA NOTICE OF PRIVACY & PATIENT RIGHTS

Notice of Privacy Practices provides information about how health information about patients may be used, disclosed, and how it is also protected.

I have been offered an opportunity to review the Notice of Patient Rights & Privacy Rights before signing this consent. I understand the terms of the Notice may change and that a copy of the revised Notice will be posted at Florida Neurosurgery and Spine Center office(s). By signing this form, I acknowledge that I have been offered and/or received Florida Neurosurgery and Spine Center PA’s Notice of Privacy Practices. The contents of the form have been fully explained to me and I have been given the opportunity to ask questions. Any questions that I have asked have been answered to my satisfaction. I certify that I understand the contents of this form in its entirety. Termination of care any result from failure to cooperate and/or comply with Florida Neurosurgery and Spine Center PA Policy and Procedures as well as failure to cooperate and/or comply with medical care and/or treatment deemed necessary by Florida Neurosurgery and Spine Center PA, physicians, and medical staff.

Signature below is only acknowledgement that you have received the Notice of Patient Rights and Privacy Rights.
A copy is available upon request.

Patient/Patient Representative Signature: ________________________________ Date: ______________

____
Initial Here

Florida Neurosurgery and Spine Center Pa
DBA

APEX SPINE and Pain Center

HIPAA- Authorization to Release Information Form

I, ______________________________, date of birth _______________, authorized the following listed person(s) to request and receive information from Florida Neurosurgery and Spine Center, PA (DBA APEX SPINE and Pain Center) regarding the following marked PHI related information and documentation.

I authorize Florida Neurosurgery and Spine Center PA, DBA APEX SPINE and Pain Center, to release:

- ☐ Appointment information
- ☐ Medication information
- ☐ Treatment information and instructions
- ☐ Surgery/procedure time, date, and location
- ☐ Billing/balances/insurance information
- ☐ Pick DME/prescriptions/instructions

To the following:

Name: ____________________________ Relationship: __________ Phone Number: ___________________

Name: ____________________________ Relationship: __________ Phone Number: ___________________

Name: ____________________________ Relationship: __________ Phone Number: ___________________

☐ I do not authorize anyone to receive any information regarding myself and my treatment.

____
Print Patient Name

____ __________________
Patient Signature Date

Florida Neurosurgery and Spine Center, P.A DBA APEX SPINE and Pain Center
155 Crystal Beach Dr. Ste 200, Destin FL, 32541
Phone: 850-252-2055 | Fax: 855-344-6080

RELEASE OF INFORMATION

Medical Records Release & Authorization Form

(Use if you would like records sent to or from our office)

Patient Name: ________________________ Date of Birth: ___________SSN: __________

Address: _____________________________City: ____________State:____ Zip: ________

Phone: _________________________ Email: ____________________________________

I authorize the custodian of records at: ____

to disclose/release the following information:

Check all that applicable:

☐All records ☐ Abstract/Summary

☐ Laboratory/pathology results ☐ Pharmacy/prescription records

☐ X-ray/radiology records ☐ Other (describe specifically) __________________

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records listed above to (use additional sheets if necessary):

Entity Name: ____

Address: ______________________________ City: __________ State: ____ Zip: ____________

Phone: _____________________ Fax: ______________ Email:__________________________

By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____

Print Patient Name

___________________________________ _______________

Patient or Guardian's Signature Date

Medical Records will be sent to other medical providers at no cost. We will not be able to send any records to another provider's office that are not our provider's records. If you need records from another provider's office, you must contract them directly to request those.