**Patient Registration Form**

**Please bring the following items to your first appointment: picture ID, insurance card, all medication bottles (including over-the counter medications) and any Advance Directives.**

Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date \_\_\_\_\_\_\_\_\_\_\_ Sex: MALE FEMALE**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_Zip \_\_\_\_\_\_**

**Alternate Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_ Zip \_\_\_\_**

**Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security No. \_\_\_\_-\_\_\_-\_\_\_\_**

**Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status: Single Married Widowed Divorced Other**

**Living Situation: Alone Spouse Children Caregiver Other**

**Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person to contact in case of emergency:**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Information (YOU MUST bring picture ID and insurance card to appointment)**

**Primary Insurance:** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to you: **SELF SPOUSE OTHER**

**Name of Previous Primary Care Dr** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any other physician/specialist currently treating you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Advance Directives** do you have any of the following? (if YES, please bring in copy to your appointment)

1. Livings will: yes no 4. Advanced directive: yes no
2. Health care surrogate: yes no 5. Do not resuscitate: yes no
3. Power of attorney: yes no

**How did you hear about this practice? (Please check one)**

* Friend/Family Member
* Kane Center
* Internet (Website/Search Engine)
* Newspaper (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Flyer/Brochure at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Health Fair or other Event
* Hospital/ER
* Insurance

**Medication List**

Please list all medications and over the counter medications you are currently taking.

**Please BRING your medication bottles to EVERY appointment.**

|  |  |  |
| --- | --- | --- |
| Name of Medication | Strength | How many times a day |
| ***Example: Aspirin*** | ***81mg*** | ***One a day*** |
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**PHARMACY:**

LOCAL**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** PHONE#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAIL ORDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **I authorize and give consent to the Day Medical staff to check my prescription history from external sources. (please check and initial) \_\_\_\_\_\_\_\_\_**

**Medical History:** (Please circle)

*Abnormal Mammogram Depression Hepatitis Postmenopausal bleeding Blood Clots*

*Abnormal Pap Smears Diabetes High blood pressure Seizures Vision Problems*

*Addiction Problems Elevated PSA High Cholesterol Shingles Weight issues*

*Arthritis Head Injury Memory trouble/loss Stomach Ulcers Cancer*

*Bleeding Problems Heart Problems Mental Illness Trouble walking Kidney Problems*

*Stroke Heart Attack Migraines Skin Problems*

*Sexually Transmitted Disease*

*OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgery & Procedure History (Include the year):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe any hospitalizations or recent illnesses:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Who in your family has/had any disease or illness? (Example: Diabetes, High blood pressure, Cancer, Heart Disease, Thyroid Disease, and Mental Illness)

|  |
| --- |
| **Family Member Medical Problem Living or Deceased Age at death** |
| Mother Living Deceased |
| Father Living Deceased |
| Siblings Living Deceased |
| Other: |

**Social History:**

1. How is your Diet? Poor Average Good Excellent
2. Do you currently smoke? Yes No If yes, start date \_\_\_\_\_\_\_\_\_\_ How much per day\_\_\_\_\_\_\_\_\_\_\_\_\_

If former smoker, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many years did you smoke? \_\_\_\_\_\_\_\_\_

How much did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Is there any tobacco exposure at home? Yes No

1. Do you drink? Yes No Beer\_\_\_\_\_\_\_\_\_\_\_\_\_\_Wine\_\_\_\_\_\_\_\_\_\_\_\_Liquor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you exercise? Yes No

If yes, what exercise do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preventative Screening:** (Please date the last time you had one of the following)

Influenza Shot\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DEXA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dermatology exam \_\_\_\_\_\_\_\_\_\_\_\_

Pneumovax Shot \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_ Eye Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevnar 13 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram \_\_\_\_\_\_\_\_\_\_\_ Dental Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Shingles Shot \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus Shot \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women**

Age of first period \_\_\_\_\_\_\_\_\_\_\_\_ Date of last normal period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth control method \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you sexually active currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No. of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. of live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Men**

Last PSA \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rectal Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active currently? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What do you want to discuss with your healthcare provider at today’s visit?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Benefits and Information Release**

**SIGNATURE REQUIRED ON THIS FORM**

I understand that the physician services of the Day Medical Center are to be billed by the Council on Aging of Martin County, Inc. Medical information regarding my visit at the Day Medical Center will be available to the Day Medical Center staff.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any service rendered that are not paid for directly by me.

I understand that the Day Medical Center has a no-show policy. As a courtesy to our office as well as to our patients who are waiting to schedule with the physician, please give us at least a 24 hour notice. If you do not cancel or reschedule your appointment with at least a 24 hour notice, we may assess a $25.00 “no-show” service charge to your account.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (PRINT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (SIGNATURE)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE

***Permission for Verbal Communication***

The Health Insurance Portability and Accountability Act (**HIPAA**)

**THIS IS A REQUIRED FORM – PLEASE FILL OUT AND SIGN**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print name of Patient** **Date of Birth Last 4 digits of Social Security Number**

***I wish to be contacted in the following manner****:*

Primary choice telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Work Cell

Secondary choice telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Work Cell

***Please indicate if you authorize us to leave a message or fax information:***

YES NOThis includes results, name of physician, date and time of appointment and any instructions.

I permit Day Medical Center, their physicians, nurses, and other personnel to discuss my health information including billing and payment information, test results or lab results in person or by telephone, with the following family members or friends involved in my medical care.

In an attempt to preserve the confidential nature of the doctor-patient relationship, please select the different locations/persons with whom or where we may leave messages regarding appointments or other administrative matters. I authorize Day Medical Center to send my records to any referring physician and or specialist to coordinate care and treatment in the future.

This may include information related to psychiatric care, drug and alcohol use, HIV testing and/or AIDS.

Limit discussions to the following medical condition(s) or services(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Phone Relationship

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Work Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Work Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Work Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_None, I do not wish my information discussed with anyone other than myself.

Release of information under this document is limited to verbal discussions as indicated above and/or limited paper records or business office documents as necessary for my immediate assistance.

This authorization is valid unless revoked. If at any time I do not want verbal discussions to be permitted between my health care providers or facility and any of the individuals name above (provided that the information has not yet been released) I must notify my Health Care Provider or contact the Day Medical Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or Authorized Signature Date**

**Relationship to Patient (Explain and/or attach Legal Documentation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Note: Medical records exceeding 25 pages cannot be received via fax. Mail to Day Medical Center. CDs cannot be accepted. Thank you.

*Authorization for Release of Medical Records*

1. **I Authorize:** 2. **To Release to:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DAY MEDICAL CENTER

Name of sending person/organization Name of receiving person/organization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 900 SE SALERNO ROAD

Street Address Street Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STUART, FL 34997

City State Zip Code City State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (772) 223-7864 (772)781-2963 (772)221-1794

Phone Fax Phone Fax

1. **INFORMATION TO BE RELEASED:** (Check all applicable)

All Information All Progress Notes Lab Reports X-Ray Reports

Electrocardiogram (ECG) Allergy Records Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **SPECIAL AUTHORIZATION:** Check applicable box (es) and sign immediately below.  By signing below, I am authorizing the office to release any and all information regarding:  Alcohol Drugs Mental Health Sexually Transmitted Diseases HIV AIDS  **Note:** If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.  Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Records from the time period:\_\_\_/\_\_\_/\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_
2. Purpose of Disclosure: (Check applicable purpose)

Continue Medical Care Payment of Insurance Claim Legal

Personal Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that this authorization shall be valid for one year. I understand that I may revoke this consent at any time except to the extent that action has already been taken.
2. I understand that a reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

Patient Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_