

ANASTASIA MEDICAL GROUP

PATIENT INFORMATION FORM

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____
(Street) (City) (State) (Zip)

TELEPHONE: Home _____ Cell: _____

PERMISSION TO LEAVE A VOICE MESSAGE: YES NO CONSENT TO TEXT: YES NO

EMAIL: _____
(Required for secure online access to your health records)

PREFERRED METHOD OF COMMUNICATION: VOICE – Home or cell TEXT
(circle one)

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY #: _____

SEX: Male Female Transgender Other

MARITAL STATUS: Single Widowed Married Divorced

RACE: White Black/ African American Native American/ Alaska Native Asian Hawaiian/Pacific Islander Hispanic/ Latino Other: _____

ETHNICITY: Hispanic/Latino Non-Hispanic/Non-Latino Other _____ Decline to report

PRIMARY LANGUAGE: English Spanish Other: _____

PREFERRED PHARMACY NAME: _____ LOCATION/PHONE #: _____

PRIMARY PHYSICIAN: _____ PHONE #: _____

REFERRING PHYSICIAN: _____ PHONE #: _____

EMERGENCY CONTACT:

NAME: _____ RELATION: _____

TELEPHONE: Home: _____ Cell: _____

Do we have your consent to discuss your care with above person? Yes / No _____
Signature

Other contact name(S) and relationship with whom we can discuss your care:

NAME: _____ RELATION: _____

PHONE: _____

ANASTASIA MEDICAL GROUP

INSURANCE INFORMATION

Primary insurance: _____	Secondary Insurance: _____
Primary Insurance ID #: _____	Secondary Insurance ID #: _____
Policy Holder's Name: _____	Policy Holder's Name: _____
DOB of Policy Holder: _____	DOB of Policy Holder: _____
Relationship to Patient: _____	Relationship to Patient: _____

Authorizations

Authorization for Treatment:

I consent to the rendering of medical care by Physician and/or mid-level providers (Nurse Practitioners, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designee as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for condition which has brought me to seek care at this practice. I understand that no guarantee or assurance has been made as to the results that may be obtained.

Authorization for Assignment of Benefits and Authorization to Release or Receive Medical Information:

- I hereby authorize Anastasia Medical Group, LLC and/or its Providers to release or receive medical or other information necessary for processing of insurance claims.
- I hereby authorize and assign Anastasia Medical Group, LLC and/or its providers all payments and/ or insurance Benefits for services rendered. I agree to complete any additional forms which may be required by my Insurance Plan for assignment of benefits. I understand that I am financially responsible for all amounts not covered by my insurance plan.
- In the event I receive payment from my Insurance Carrier, I agree to endorse any payment I receive to Anastasia Medical Group, LLC for which these fees are payable.
- I authorize, until further notice, that any of my medical records may be released to any physician that I am referred to and I authorize that any of my medical records be released, on a continuing basis, to my chiropractor, dentist, optometrist, audiologist, psychologist, that I am seeing, unless specified otherwise.
- I authorize disclosure of protected Health Information without prior consent in case of an emergency.
- I understand I have the right to revoke the authorizations on this form at any time by notifying Anastasia Medical Group, LLC in writing, except to the extent that Anastasia Medical Group has already taken action in reliance upon them. These authorizations will remain valid until I revoke them in writing.

A Photocopy of these authorizations and agreement shall be valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PATIENT'S SIGNATURE (OR RESPONSIBLE PARTY): _____

NAME: _____

DATE: _____

**ANASTASIA MEDICAL GROUP
PATIENT HISTORY**

Name: _____

Date: _____

Medical concern which brings you to our office: _____

Personal History:

	Alive Y/N	Medical Problems	Habits:
Father			Smoking: no / yes / ready to quit; if yes _____ packs per day _____ years
Mother			Caffeine (coffee/ tea/ cola): no / yes; if yes _____ drinks/day
Brother			Alcohol: no / yes; if yes _____ drinks/day
Sister			Other substance usage: no / yes; if yes, details _____
Other Family Member			

Allergies/Intolerances to medicines, foods, or environmental factors:

Name:	Type of reaction	Name:	Type of reaction
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Current Medications (include over the counter medications and natural remedies):

Name	Dose & frequency	Date started	Name	Dose & frequency	Date started
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

Past Surgery History: No / Yes; if yes please provide details:

What	When (year)	Where	Surgeon
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Additional medical conditions including hospitalization history: Negative / Positive; if positive, please provide details:

What	When (year)	Where	Attending Physician's Name
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Immunization History: Please provide your last date of immunization

Flu Vaccine: _____
 Pneumonia Vaccine (Pneumovax and Prevnar): _____
 Tetanus vaccine: _____
 Shingles Vaccine: _____

Other Examination: (Please provide name of Doctor and date **if applicable**)

Last Colonoscopy date: _____ Doctor's name: _____
 Last Mammogram date: _____ Doctor's name: _____
 Last Eye Exam date: _____ Doctor's name: _____

***NOTE: THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

SIGNATURE: _____

DATE: _____

ANASTASIA MEDICAL GROUP

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-prescribing is defined as a physician’s ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-prescribe program. These include:

- **Formulary and benefit transactions-** Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history-** Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification-** Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient’s prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Anastasia Medical Group, LLC can request and use your prescription medication history from other healthcare providers and/or third parties pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Anastasia Medical Group, LLC to enroll me in the E-prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature of Patient or Guardian

Patient DOB

Print Name


Date

Relationship to Patient

ANASTASIA MEDICAL GROUP

PATIENT PORTAL AND HEALOW APP ACCESS

You can access your health records via Patient Portal and/or Healow App on your Mobile device anywhere, anytime.

	Request Appointment Request Prescription Refills View/download medical history and medications Review Lab Reports (once reviewed by the Doctor) Request billing Information, View Statement, and Pay on line Ask non-Emergent medical questions Pay Bills.
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Please provide your e-mail address for Patient Portal.

E-mail Address (*Please print*): _____

You can easily link **Healow App** on your mobile with our Practice:

1. Download the Free Healow App
2. Enter Practice Code **FHGCAA**
3. Enter Username and Password (same as Patient Portal)

Consent to Email and/or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients may be contacted via email and/or text message to remind you of your appointment, to obtain feedback, billing statement and to provide general health reminders/information.

By signing below, I consent to receiving appointment reminders and other healthcare communications/information at my email or text message on my cell phone. I understand that this request will apply to all future appointment/feedback/health information unless I request a change in writing (see revocation section below).

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan.

Patient Signature _____ Date _____

Revocation:

_____ I hereby revoke my request for all future communications from the Practice via **email**.

_____ I hereby revoke my request for all future communications from the Practice via **text messaging**.

Note: This revocation only applies to communications from this practice.

Patient Name: _____

Patient/ representative Signature: _____

Date: _____

ANASTASIA MEDICAL GROUP

FINANCIAL POLICY

Welcome to Anastasia Medical Group, LLC! The office of Dr. Neerukonda, and Dr. Pereira, and Cindy Chaconas

Our goal is to provide you with quality state-of-the-art care in a cost-effective manner. In order to maintain that goal, we have established the following policies to improve communication regarding appointments, medical records and your financial responsibility at the time of service or prior any scheduled surgery. If you have any questions, please feel free to ask a staff member.

Your Insurance Policy: It is the policy of Anastasia Medical Group to collect any applicable co-payment, co-insurance and/or deductible at the time of service or prior to surgery. Please be aware that your insurance may require a higher co-payment for a specialist office visit.

At this time our office is a participating provider for most insurance plans and most major insurance networks. If we are not a participating provider for your insurance plan we will still file your insurance claim as a courtesy. However, you will ultimately be responsible for any fees.

If you are enrolled in a managed care insurance plan (HMO) you must obtain a referral from your Primary Care Physician (PCP) before your office visit. We will assist you in this process if applicable. Please be aware that without a referral from your PCP your visit may have to be rescheduled.

Pre-certification or authorization for a service **is not a guarantee of benefits**. Benefits are determined when your insurance company receives our claim. If no benefits are due, you will be responsible for any balance pertaining to denied services. In certain situations, there may be appeal rights for our office. If so, we will attempt an appeal even without you requesting us to do so. If no appeal rights are available for our office, you will be mailed a statement for the balance due. Please be aware that any appeal rights available to the patient will have to be handled by the patient.

If your insurance policy is new, you may be subjected to a pre-existing conditioned waiting period. This does not apply to Medicare coverage. Any services not paid by your insurance company for this reason will be your responsibility.

Any fees we charge are for our services only. Any services provided outside our office will be billed separately by that provider. This would include laboratory, CT scans, MRI Scans and surgery performed at the hospital or any other facility. Please speak directly with those providers regarding their fees.

Federal Law prohibits our office from writing off any allowed balance due after your insurance company pays. Patients that are experiencing financial difficulties should speak to the office manager prior to their office visit.

Missed Appointments/Late Cancellations:

Missed appointments represent a cost to us, to you and other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your appointment for an office visit. We reserve the right to charge \$40.00 for a missed or late cancellation for an office visit. A fee of \$200.00 may be applied to a missed or late cancellation of an office procedure. This fee is not covered by your insurance company. Excessive abuse of scheduled appointments may result in a discharge from our practice. Our office understands that emergencies do arise, but please call our office to discuss this matter with a staff member.

REFUNDS: Overpayments will be refunded upon request to the responsible party within 30 days. Please keep this in mind that an overpayment from your insurance company is not a credit to you and cannot be refunded to you.

Medical Records: Upon request we will provide you with copies of your medical records. However, this can be time consuming, so we charge \$1.00 per page for first 25 pages and \$0.25 per page for additional pages, with a minimum of \$5.00. Your insurance company does not cover this fee. Please allow up to 30 days for this request to be processed.

Your Account: You will be mailed a statement when balance becomes due. We request that you pay upon receipt of the statement. Should you have any questions concerning your statement please do not hesitate to call our office. We will make an attempt to collect any prior balance at your office visit as well as any applicable co-payment/co-insurance and/ or deductible. Your account must be current prior to any scheduled appointments. If your account is past due then future services may be postponed. For your convenience our office accepts cash, checks, Visa and MasterCard. **There will be a \$35.00 charge for returned checks. Contact Stephanie with billing questions at 904-461-0821.**

Copay/Co-insurance/Deductible: It is our policy to collect your co-pay, co-insurance and deductible at the time services are rendered.

Seriously past due accounts those older than 120 days or those failing to honor agreed-upon terms- will be sent to a collection agency. Our office will forward your account balance plus any fees charged by the collection agency. Once the collection agency receives your information your past due debt will be reported on your credit history. Additionally, you will be dismissed from our practice for financial matters and will have to seek healthcare elsewhere.

Patient dismissal: Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice.

I hereby understand and agree to the financial policy of Anastasia Medical Group.

Patient Name: _____

Signature: _____ **Date** _____

NOTICE OF PRIVACY PRACTICES

Effective Date: November 18, 2013

<p>THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.</p> <p>1. Your Rights You have the right to:</p> <ul style="list-style-type: none"> • Get a copy of your paper or electronic medical record • Correct your paper or electronic medical record • Request confidential communication • Ask us to limit the information we share • Get a list of those with whom we've shared your information • Get a copy of this privacy notice • Choose someone to act for you • File a complaint if you believe your privacy rights have been violated <p>2. Your Choices You have some choices in the way that we use and share information as we:</p> <ul style="list-style-type: none"> • Tell family and friends about your condition • Provide disaster relief • Include you in a hospital directory • Provide mental health care • Market our services and sell your information • Raise funds <p>3. Our Uses and Disclosures We may use and share your information as we:</p> <ul style="list-style-type: none"> • Treat you • Run our organization • Bill for your services • Help with public health and safety issues • Do research • Comply with the law • Respond to organ and tissue donation requests • Work with a medical examiner or funeral director • Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions <p>4. Our Responsibilities</p> <ul style="list-style-type: none"> • Maintain the privacy and security of your protected health information <p>1. Your Rights When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.</p> <p>Get an electronic or paper copy of your medical record</p> <ul style="list-style-type: none"> • You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this by contacting our Privacy Officer. • We will provide a copy or a summary of your health information, usually within 30 days of your written request. We may charge a reasonable, cost-based fee. <p>Ask us to correct your medical record</p> <ul style="list-style-type: none"> • You can ask us in writing to correct health information about you that you think is incorrect or incomplete. Ask us how to do this by contacting our Privacy Officer. • We may say "no" to your request, but we'll tell you why in writing within 60 days. 	<p><i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i></p> <p>In these cases we never share your information unless you give us written permission:</p> <ul style="list-style-type: none"> • Marketing purposes • Sale of your information • Most sharing of psychotherapy notes <p>In the case of fundraising:</p> <ul style="list-style-type: none"> • We may contact you for fundraising efforts, but you have the right to opt out, and we will honor your request if you tell us that you would not like to receive these communications. <p>3. Our Uses and Disclosures How do we typically use or share your health information?</p> <ul style="list-style-type: none"> • We typically use or share your health information in the following ways. <p>Treat you</p> <ul style="list-style-type: none"> • We can use your health information and share it with other professionals who are treating you. • <i>Example: A doctor treating you for an injury asks another doctor about your overall health condition.</i> <p>Bill for your services</p> <ul style="list-style-type: none"> • We can use and share your health information to bill and get payment from health plans or other entities. • <i>Example: We give information about you to your health insurance plan so it will pay for your services.</i> <p>Run our organization</p> <ul style="list-style-type: none"> • We can use and share your health information to run our practice, improve your care, and contact you when necessary. • <i>Example: We use health information about you to manage your treatment and services.</i> <p>How else can we use or share your health information?</p> <ul style="list-style-type: none"> • We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. <p>Help with public health and safety issues We can share health information about you for certain situations such as:</p> <ul style="list-style-type: none"> • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety <p>Do research</p> <ul style="list-style-type: none"> • We can use or share your information for health research, so long as we obtain documentation that an alteration to or waiver of the individual authorization has been approved by either an Institutional Review Board (IRB) or privacy board. <p>Comply with the law</p> <ul style="list-style-type: none"> • We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. <p>Respond to organ and tissue donation requests</p> <ul style="list-style-type: none"> • We can share health information for activities authorized by law <p>Work with a medical examiner or funeral director</p> <ul style="list-style-type: none"> • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
<p>Request confidential communications</p> <ul style="list-style-type: none"> • You can ask us in writing to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Ask us how to do this by contacting our Privacy Officer. • We will say "yes" to all reasonable requests. <p>Ask us to limit what we use or share</p> <ul style="list-style-type: none"> • You can ask us in writing not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. Ask us how to do this by contacting our Privacy Officer. • If you pay for a service or health care item out-of-pocket in full, you can ask us in writing not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. Ask us how to do this by contacting our Privacy Officer. <p>Get a list of those with whom we've shared information</p> <ul style="list-style-type: none"> • You can ask us in writing for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. Ask us how to do this by contacting our Privacy Officer. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. <p>Get a copy of this privacy notice</p> <ul style="list-style-type: none"> • You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Ask us how to do this by contacting our Privacy Officer. <p>Choose someone to act for you</p> <ul style="list-style-type: none"> • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action. <p>File a complaint if you feel your rights are violated</p> <ul style="list-style-type: none"> • You can complain if you feel we have violated your rights by contacting the Privacy Officer listed below. • You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. • We will not retaliate against you for filing a complaint. <p>2. Your Choices For certain health information, you can tell us your choices about what we share.</p> <ul style="list-style-type: none"> • If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. <p>In these cases, you have both the right and choice to tell us to:</p> <ul style="list-style-type: none"> • Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory 	<p>Address workers' compensation, law enforcement, and other government requests We can use or share health information about you:</p> <ul style="list-style-type: none"> • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services <p>Respond to lawsuits and legal actions We can share health information about you in response to a court or administrative order, or in response to a subpoena.</p> <p>4. Our Responsibilities</p> <ul style="list-style-type: none"> • We are required by law to maintain the privacy and security of your protected health information. • We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. • We must follow the duties and privacy practices described in this notice and give you a copy of it. • We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. • For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. <p>Changes to the Terms of this Notice We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. http://www.anastasiamedicalgroup.com/</p> <p>Privacy Officer If you would like to contact us for information about this notice or to complain about our privacy practices, please contact: Kalpana Shrestha, Privacy and Security Officer Anastasia Medical Group, LLC 1301 Plantation Island Drive South Suite 203A, St. Augustine, Florida 32080 Phone #: (904) 461-0821, Fax #: (904) 461-0823</p> <p>Other Instructions for Notice Under Florida law, we will never share treatment records without your written permission for the following areas, unless an exception applies: Alcohol and substance abuse Genetic testing HIV/AIDS Mental Health</p> <p>Acknowledgement You will be asked to sign an acknowledgement of your receipt of this Notice of Privacy Practices. We are required by law to make a good faith effort to provide you with our Notice of Privacy Practices and obtain such acknowledgement from you. However, your receipt of care and treatment from Anastasia Medical Group, LLC is not conditioned upon your providing the written acknowledgement.</p>

Acknowledgement of Receipt

I hereby acknowledge that I have received and reviewed a Copy of Anastasia Medical Group, LLC's Notice of Privacy Practices.

_____ Date _____
 (Signature of patient or patient's representative)

Printed name of patient/patient's representative: _____

Relationship to the patient: _____

ANASTASIA MEDICAL GROUP

1301 PLANTATION ISLAND DRIVE SOUTH, SUITE 203A, ST. AUGUSTINE, FL32080

PHONE #: (904) 461-0821, Fax #: (904) 461-0823

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. PATIENT INFORMATION	NAME: _____ DATE OF BIRTH: _____ SSN #: _____ ADDRESS: _____ TELEPHONE #: _____
2. TYPE OF RELEASE AUTHORIZATION PHYSICIAN INFORMATION	<input type="checkbox"/> I AUTHORIZE ANASTASIA MEDICAL GROUP <u>TO RELEASE</u> MEDICAL RECORDS INFORMATION <u>TO:</u> <input type="checkbox"/> I AUTHORIZE ANASTASIA MEDICAL GROUP <u>TO OBTAIN</u> MEDICAL RECORDS INFORMATION ON ME <u>FROM:</u> NAME OF PHYSICIAN: _____ ADDRESS: _____ PHONE #: _____ FAX #: _____
3. PURPOSE FOR REQUEST	<input type="checkbox"/> CONTINUITY OF CARE <input type="checkbox"/> ATTORNEY <input type="checkbox"/> PERSONAL <input type="checkbox"/> INSURANCE CLAIM <input type="checkbox"/> CHANGE OF INSURANCE <input type="checkbox"/> OTHER: _____
4. INFORMATION NEEDED (CHECK OFF ALL THAT APPLY)	<input type="checkbox"/> ALL <input type="checkbox"/> LABORATORY RESULTS <input type="checkbox"/> X-RAY REPORTS <input type="checkbox"/> HISTORY AND PHYSICAL <input type="checkbox"/> IMMUNIZATION RECORD <input type="checkbox"/> OTHER: _____

I specifically consent to release information relating to: (initial selection)

STD _____ HIV/AIDS _____ TB _____ Drug/Alcohol _____ Mental Health _____ WIC Eligibility _____

EXPIRATION DATE: This authorization will expire on (_____). I understand that if I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

REDISCLASURE: I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. I understand that I may inspect or copy the information to be used or disclosed in 45 C.F.R. 164.524.

REVOCATION: I understand that I have the right to revoke this authorization any time in writing. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. 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, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy.

Patient's /Legal Representative Signature: _____ Date: _____

If signed by Legal Representative, relationship to patient: _____