Charlotte Pain Management Center

3109 Tamiami Trail Unit 3 Port Charlotte, FL 33952
941-629-3000 Fax: 941-629-6711

Dear Patient,

To avoid confusion and delays in getting your new patient appointment or having to cancel your scheduled appointment, we must be able to obtain your complete medical record. I will contact all of the doctors you have seen over the past 5 years and get all your records for you at **NO COST**.

I must have the phone number and fax number to **EVERY DOCTOR** YOU HAVE SEEN IN THE PAST 5 YEARS EVEN IF THEY ARE NOT IN THE State of Florida. **I have highlighted** this new patient packet myself on page 3. Even if you have all of your medical records or believe the last doctor you have seen has all of your records, it is the policy of our practice to obtain your medical records from each and every doctor's office individually.

For Example:

Primary Care Doctor, Orthopedic Doctor, Neurologist, Neurosurgeon, Endocrinologist, Gynecologist, Plastic Surgeon, Walk In Clinic, Etc……

Thank you,
John Distasio
Intake Coordinator

Charlotte Pain Management Center

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Dear Patient,

We are pleased to welcome you to our practice, and look forward to helping you with your medical condition. You are important to us and we look forward to developing a positive and healthy relationship. To start things off, we have assigned John DiStasio to be your personal intake coordinator. John will be contacting your other medical providers and gathering all your medical records for review by the Doctors. John is available to you 5 days a week between the hours of 9:00 am and 4:00 pm to answer any and all of your questions and concerns. His direct phone number is 941-256-8002.

Attached is our New Patient Packet and Pain Management Contract which should be **filled out completely with fax numbers** and brought back to our office before we can schedule your first appointment.

DRUG TESTING POLICY.

It is the policy of Charlotte Pain Management Center not to accept any patient that abuses **any illegal substance** or takes any medication that they do not have a valid prescription. We do enforce our policy by doing **urine drug screening on every visit** and discharge any patient found to be positive for any illegal or not prescribed controlled substance. **This includes Marijuana.**

UNINSURED.

A new patient office visit for patients without insurance is $295.00 and will require a $100.00 deposit when we receive this packet. The Deposit is 100% refundable provided you cancel your appointment with at least a 48 hours notice, without this notice a refund is not possible. Follow up appointments are $230.00.

Should you have any questions or concerns please contact your intake coordinator, John DiStasio, 1-941-256-8002

Sincerely,

Charlotte Pain Management Staff

Charlotte Pain Management Center

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941-629-3000 Fax: 941-629-6711

PATIENT INFORMATION:

Name: _____ Age: _____ Date of Birth: _____
(Last) (First) (Middle)

Address: _____ City: _____

State: _____ Zip: _____ Social Security #: _____ Sex: _____

HM Phone: _____ WK Phone: _____ Cell: _____ Email: _____

Employer: _____ Employer Phone: _____

SPOUSE / SIGNIFICANT OTHER INFORMATION: May we disclose information to this person? **Y** **N**

Name: _____ Date of Birth: _____ Social Security #:_____

WK Phone: _____ Cell: _____ Email: _____

Employer: _____ Employer Phone: _____

EMERGENCY CONTACT INFORMATION: May we disclose information to this person? **Y** **N**

Name: _____ Relationship: _____ HM Phone: _____

Address: _____Cell:_____

INSURANCE INFORMATION:

Do you have health Insurance? YES:____ NO:____"*If you are uninsured a $100.00 deposit is required with this packet*"

Primary Insurance: _____Address: _____

Subscriber #: _____ ID#: _____ Group #: _____

Secondary Insurance: _____Address: _____

Subscriber #:_____ID#: _____ Group #: _____

Auto/Workers Compensation Carrier: _____

Address: _____Date of Injury: _____

Claim #: _____ Adjuster: _____ Adjuster Phone #: _____

Referring Doctor: _____ **Phone:** _____

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

Name: _____ DOB: _____

Address: _____

_____

Phone: _____ Last 4 digits of SS#: _____

REQUEST OF PATIENT INFORMATION FROM:

[1] Doctor's Name:_____**State:**_____**Last Visit:**_____

Phone Number:_____ **Fax Number:**_____**<<<<MUST HAVE FAX #**

---

[2] Doctor's Name:_____**State:**_____**Last Visit:**_____

Phone Number:_____ **Fax Number:**_____**<<<<MUST HAVE FAX #**

---

[3] Doctor's Name:_____**State:**_____**Last Visit:**_____

Phone Number:_____ **Fax Number:**_____**<<<<MUST HAVE FAX #**

---

[4] Doctor's Name:_____**State:**_____**Last Visit:**_____

Phone Number:_____ **Fax Number:**_____**<<<<MUST HAVE FAX #**

---

[5] Doctor's Name:_____**State:**_____**Last Visit:**_____

Phone Number:_____ **Fax Number:**_____**<<<<MUST HAVE FAX #**

PLEASE SEND THE FOLLOWING MEDICAL RECORDS BEFORE_____ IF POSSIBLE.

All Records: X

Imaging Reports - MRI/ CT/ X-RAY: X By Fax: X

Patients Scheduled Appointment:_____

I, the undersigned authorize the above information to be sent to: Charlotte Pain Management Center- 3109Tamiami Trail, Unit 3, Port Charlotte, FL 33952. *This authorization extends to history of illness, diagnosis, and therapeutic information: including any treatment for drug and alcohol abuse, HIV testing and/or AIDS related information. In compliance with Florida Statute 397.507(7), 394, 4615, and Federal Law CFR 4.2.* **I may revoke this authorization at any time in writing, but if I do, it will not have an affect or any actions taken prior to receiving the revocations**.

Signature of Patient/Guardian:_____ **Date:**_____

WE MUST HAVE THE MEDICAL RECORDS FAX NUMBERS TO GET YOUR RECORDS. If we can not obtain your medical records we will have to postpone and reschedule your New Patient appointment.

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Conditions of Medical Service and Agreement

In consideration of and as a condition of the medical services I will receive at Charlotte Pain Management Center, I agree to the following:

(1) I hereby assign and authorize payment of covered insurance benefits, including major medical benefits, whether payable to me by Blue Cross/Blue shield, Medicare any commercial insurance company or managed health care plan or directly payable to Charlotte Pain Management Center, now or in the future.

(2) I understand that my health insurance may not cover some or any of the medical services I may receive. *I understand that I am responsible for any and all charges not covered or actually paid by my health insurance to Charlotte pain Management Center.* That means, among other things, that I am responsible for deductibles, coinsurance and payments from an insurance company directly to me. I will take responsibility for making certain that any payment I send gets to the billing office of Charlotte Pain Management Center, located at 3109 Tamiami Trail, Unit 3, Port Charlotte, FL 33952.

(3) I promise to pay Charlotte Pain Management Center all balances due within (60) days of the presentation of my bill. My bill will be considered presented three (3) days after mailing to the address I provide, and sixty (60) days after presentation my bill becomes delinquent, accrues interest at the rate of ten (10) percent per month, and may be submitted for collection. If my bill has to be submitted for collection, I promise to pay all costs associated with it, including any attorney's fees that may be incurred. A collection fee of thirty percent (30%) of the balance is assessed. I will notify Charlotte Pain Management Center promptly of any change of address.

(4) I have disclosed to Charlotte Pain Management Center the names of all my health insurance providers and any tie-in health coverage. *My health care coverage is in full force and in effect now*. If my health care coverage requires that I receive a referral for these medical services and I did not obtain one, I promise to do so immediately and submit it to Charlotte pain Management Center. I authorize the release of any and all medical information that may be required to process the claims for payment of the medical services I receive at Charlotte Pain Management Center and I waive all privilege and confidentiality to that extent.

(5) I will ask clarification of any medical service, treatment or procedure I may not understand prior to receiving it and I acknowledge and accept that the results of any such service, treatment or procedure are not and cannot be guaranteed.

(6) If I am currently involved, or, if after beginning my treatment at Charlotte Pain management Center, I become involved in pursuing a personal injury claim against a third party, I understand that at my request and with my authorization Charlotte Pain Management can and will provide my attorney with all of my records of treatment. As a condition of treatment, I agree that having requested and received copies of my medical records, I (or my attorney) will mot seek to subpoena my physician(s) at Charlotte Pain Management Center to provide factual information already contained in or covered by my records nor to provide expert testimony (or include their names on any list of expert witnesses) in my case without their prior written consent.

I have read through this document and assert that I understand it and sign it freely. Any signed copy of this document may be considered as valid as the original.

_____ _____

Signature of Patient Dated

_____ _____

Signature of Insured (if applicable) Dated

MEDICARE LIFETIME MEDIGAP ASSIGNMENT. Sign below if you have a MEDIGAP insurance policy.

I assign and authorize payment of MEDIGAP benefits to Charlotte Pain Management Center for any services I receive there. I authorize any holder of medical information that may be necessary to determine benefits to release it to the Health Care Financing Administration (HCFA) and its agents.

_____ _____

Signature of Patient Dated:

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PAYMENT POLICY - Payment is due at Time of Services.

INSURANCE BILLING SERVICES:

As a service to our patients with insurance, we fill out and send your insurance claim into your insurance carrier. Upon admission to Charlotte Pain Management Center, you have contractually agreed to pay for services rendered to you. If you have health insurance coverage, Charlotte pain Management center will agree to file your initial claim(s) provided we have complete information at the time of service. However, your health insurance contract (s) is between you and the insurance carrier. Because of this relationship, you have a primary responsibility to pay for the services and provide follow-up communication with your health insurance carrier(s) if necessary. Should your insurance reject your claim, for any reason, you are financially responsible. If your health insurance coverage requires you to pay a deductible, percentage and/or co-pay, these amounts will be due the day of service. We will try to give you an estimate of the amount you may owe before your visit upon your request. If we are contracted providers with your plan, you are not eligible for any additional discounts beyond the discount agreed upon with your health insurance carrier.

YOUR RESPONSIBILITY IS TO KNOW YOUR PLAN:

Know your yearly deductible and when it is due.

Know your maximum allowed fee for services in a calendar year.

Know what the percentage is that your coverage pays for our services.

Know that you have to follow up on claims submitted to your insurance company.

WE REQUIRE:

Balance paid in full by patient sixty (60) days after processing of claim(s) by insurer.

NON-INSURED PATIENTS:

We do not accept attorney liens. All services must be paid on the day of your appointment. No payment plans are available at this time.

I have read and understand the office policy on payment for services rendered at Charlotte Pain Management Center, I have also signed the Condition of Medical Service and Agreement form and agree to the contents of both forms.

Patient Signature: _____ **Date:** _____

Printed Name: _____

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PATIENT HEALTH HISTORY

NAME: _____

Date of Birth: _____ **Age** _____ **Male:** ☐ **Female:** ☐

Referring Physician: _____

Primary Care Physician: _____

Where is your pain? _____

When did the pain start? _____

What makes it better? _____

What makes it worse? _____

MEDICATIONS: Please list your current medications. (Include Strength, Dose/Day, Prescribing Physician, Last Date filled.)

_____

_____

_____

_____

FAILED MEDICATIONS: Please list any previously taken pain medications that you stopped taking and the reasons for stopping. _____

_____

_____

ALLERGIES: Do you have symptoms like red itchy eyes, general itching, shortness of breath, wheezing, fast heartbeat, feeling faint, nausea, or vomiting when exposed to any of the following:

DYE _____ **IODINE** _____ **LATEX** _____ **NO KNOWN DRUG ALLERGIES** _____

Medications: _____

TREATMENTS: Check any treatments you have had.

☐ **Physical Therapy:** **Pain Relief? (Circle One) Yes – No – Temporary**

☐ **Massage Therapy:** **Pain Relief? (Circle One) Yes – No – Temporary**

☐ **Chiropractor** ☐ **Tens Unit? Pain Relief? (Circle One) Yes – No – Temporary**

☐ **Surgery: (Circle One) Neck Back Knee Wrist Elbow Head**

Pain Relief? (Circle One) Yes – No – Temporary

☐ **Injections: (Circle One) Epidural Steroids Synvisc**

Pain Relief? (Circle One) Yes - No – Temporary

PAIN QUALITY: Circle any that may apply.

Constant Throbbing Burning Sharp Cramping Pressure

Aching Pins & Needles Shooting Numbness Cutting

PAST MEDICAL HISTORY: Have you had any of the following health problems? Please circle all that apply.

High Blood Pressure Angina Stroke Heart Attack Diabetes Hypothyroid Hyperthyroid

Migraines Seizures Kidney Disease Liver Disease Hep A Hep B Hep C Arthritis

Alcohol/Drug Problem Stomach/Intestinal Problems Cancer Chronic Cough COPD

Asthma Emphysema Tuberculosis HIV Anemia Psychological or Psychiatric Problems

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SOCIAL HISTORY: Circle all that apply.

Employed? _____ Full Time Part Time Unemployed Disabled Married Single Divorced

Living with significant other. Number of Children? _____ Oldest to youngest _____

Smoke? Cigars Cigarettes How many packs per day? _____ Alcohol? How many drinks daily? _____

Per week? _____ Illegal/Street Drugs? In the past? Type? _____

_____

SURGERIES: Please list.

Surgery Type	Date	Physician	Hospital

FAMILY HISTORY: Please list any pertinent family medical history.

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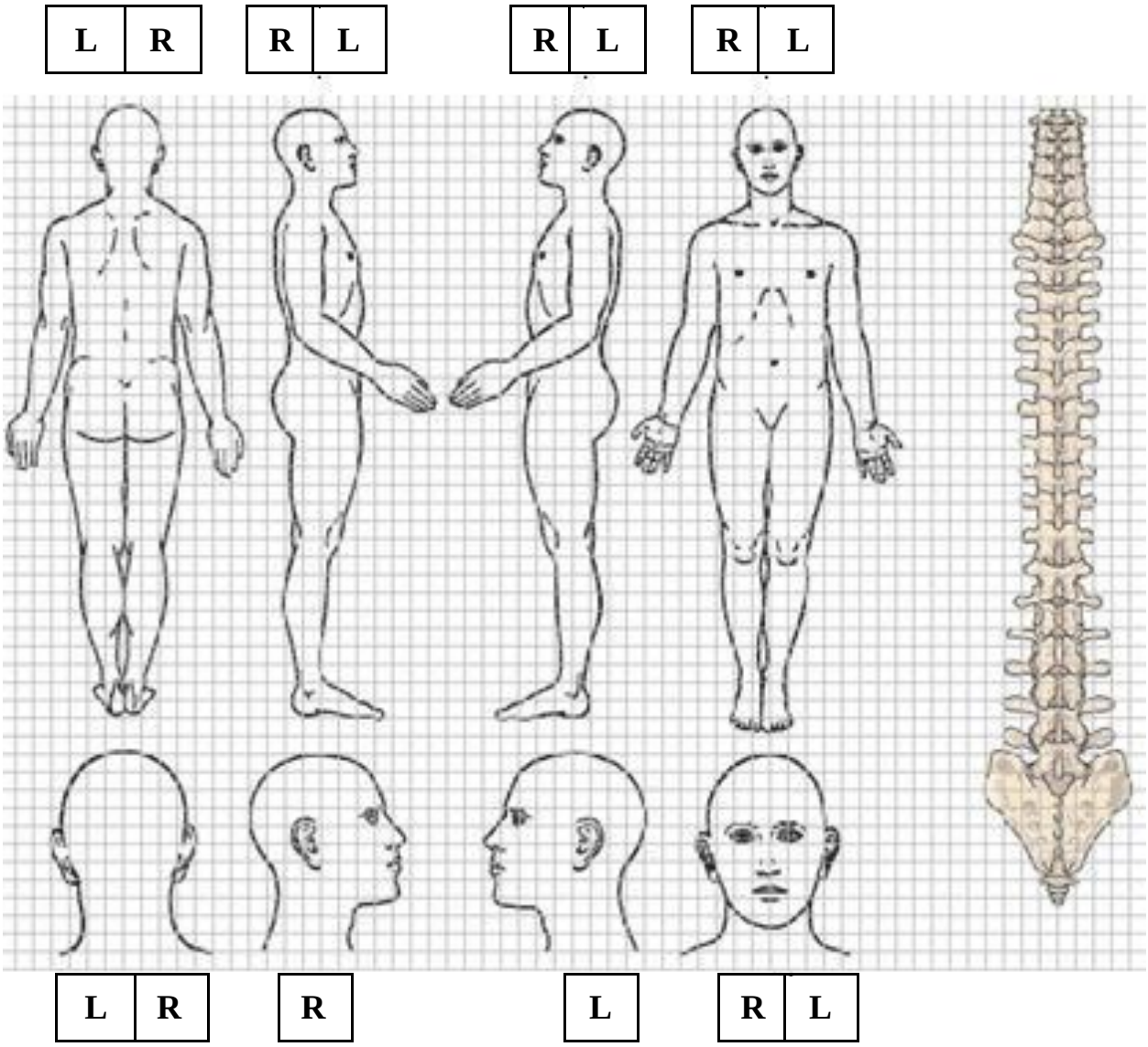

Patient, please mark areas of your pain on the above diagram.

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PAIN MANAGEMENT/NARCOTIC TREATMENT AGREEMENT

I have agreed to use narcotics as part of my treatment for my chronic pain. I understand these drugs are very useful, but have a potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my physician is prescribing such medication to help manage my pain, I agree to the following conditions, without reservations:

1. ***I am responsible for the controlled substance medications prescribed to me***. I agree to take the medication only as prescribed. I understand that increasing my dose without the authorization and supervision of my physician could lead to drug overdose, causing severe sedation, respiratory depression and death.
2. I will not request or accept controlled substance medication ***from any other physician*** or individual while I am receiving such medication from the Charlotte Pain Management Center.
3. I understand the side effects, related to narcotic medication, include ***nausea and vomiting, drowsiness, constipation***, mental slowing, flushing, sweating, itching, and urinary difficulty. It is my responsibility to notify my physician of any side effects that continue or are severe. ***I will also inform all of my other treating physician(s) of this agreement to avoid prescription duplication.***
4. ***I understand the pain medication is strictly for my own use***. Pain medicines should never be given to others.
5. I understand medications like Valium, Ativan, Xanax, Fiorinal or Ambien, certain muscle relaxants like Soma, antihistamines like Benadryl or Atarax, and alcohol may produce profound sedation, respiratory depression, blood pressure drop, and even death when taken inappropriately.
6. I understand that mind altering drugs, including marijuana, cocaine, ecstasy, etc., are especially dangerous and deadly, and ***should never be used.***
7. I understand that pain prescriptions will ***not*** be mailed. I will pick up my refill prescriptions at the Charlotte Pain Management Center every month or as designated by my physician.
8. ***I am responsible for my narcotic/pain prescriptions***. I understand that refill prescriptions:
    - ***Can only be written for a one month supply for most medications and will be filled at the same pharmacy***. The allowance of refills on prescriptions is at the discretion of my physician, but also dictated by the governing laws of the state.
    - Request for a prescription to be re-written through no fault of Charlotte Pain Management Center will incur a charge, ***payable at the time the prescription is re-written***.
    - Request for prescriptions refills for pain medication need to be made ***Monday through Thursday, 8:00 am to 3:00 pm.*** Please do not wait until you have only one pill left before calling for a prescription refill as refill requests may take 72-96 hours to fulfill. ***No refill prescriptions will be written after 3:00 pm, on holidays, or on weekends.***
    - ***I am responsible for the safety of my medications***. ***Refills will not be made for lost, stolen or misplaced medications***. If I run out of my medications early because I took more medicine than prescribed by my physician, not only will my refill be denied, but also I run the risk of dismissal from my physician's practice. I will be allowed to take less than prescribed if my medicine is not needed, but not more without the permission of my physician.
    - Can only be filled by a pharmacy in the State of Florida, even if I am a resident of another state.
9. If my physician changes my pain medication, I will turn into the clinic the appropriate balance of medication, ***before picking up my new prescription***. The type and quantity of the turned in medication will be recorded in my patient chart. I will not dispose of or flush the medicine down the toilet on my own. Hoarding of old medications is prohibited.
10. ***I understand that narcotic/pain medications, along with all medications, pose a danger to children and I will safeguard these in my home***.
11. While physical dependence is to be expected after long-term use of narcotic pain medication, signs of addiction (and psychological dependence) shall be interpreted as a need for weaning and detoxification.
    - ***Physical dependence*** is common to many drugs such as blood pressure medication, anti-seizure medicines and narcotics. It results in biochemical changes such that abruptly stopping these drugs can cause a withdrawal response.

• ***Addiction*** is a psychological and behavioral disease that is recognized when a patient abuses the drug to obtain mental numbness and euphoria. When the patient shows a craving behavior or "doctor shopping," when the drug is quickly escalated without correlation to pain relief and/or when the patient shows a manipulative or abusive attitude toward the physician to obtain the drug. If the patient exhibits such behavior, the drug will be tapered; such a patient is not a candidate for the narcotic medication and he/she may be referred to a narcotic detoxification program and/or be discharged from the practice.

• ***Tolerance*** is an expected pharmacological property of certain drugs and is defined as a need for higher doses to maintain the same drug effect.

12. I understand that if I participate in any illegal, deceitful or fraudulent activities I will be discharged from the practice and appropriate criminal/legal action will be invoked. This includes "dealing" prescription drugs and forging or altering prescriptions in any manner or form.

13. If it appears to the physician that there is no improvement to my daily function or quality of life from the prescribed medications, they will be discontinued. I will gladly taper the medicine as instructed by my physician.

14. ***I agree to submit to supervised/witnessed urine and blood screening at any time as determined by my physician or his designee to detect the use of both prescribed and non-prescribed medications, and I will be financially responsible for the test regardless of payer source. I also agree to pill counts every visit and will have my medication bottles with me to document the proper use of my medications.***

15. ***I authorize the release*** of any information and hospital records by the pain physician or his/her designee to other healthcare providers, my insurance company or other reimbursing agencies. I also authorize any pharmacy, hospital, medical clinic, law enforcement agency and physician to release medical information to my pain physician.

16. I understand that, if in the opinion of my physician, I did not follow the above conditions; my physician may determine that narcotic therapy is no longer appropriate for me. I will then be gradually taken off these medications and other therapies will be used, or I may be discharged from my physician's care.

I also agree to hold the Charlotte Pain Management Center and my treating physicians free of any liability or responsibility should I violate any of the above conditions.

I, (PRINT NAME) _____

(PRINT DATE OF BIRTH)_____, have read all pages of the pain management/narcotic treatment contract or it has been read to me and all my questions regarding the treatment of pain with narcotic/pain medicines have been answered to my satisfaction. I hereby give my consent to participate in narcotic/pain medication therapy.

PATIENT SIGNATURE: DATE:

_____

PHYSICIAN SIGNATURE: DATE:

_____

WITNESS: DATE:

_____

PHARMACY NAME, ADDRESS, and PHONE:

_____

_____

_____

_____

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MEDICAL COMPLIANCE AGREEMENT

1- I will buy a safe and keep all of my medication locked up to prevent it from being stolen.

2- I will not accept narcotic prescriptions from any other doctor.

3- I will not share any of my medication with anyone for any reason.

4- I will not take any prescription medication unless it's prescribed to me.

5- I will not partake in any illegal substance or activity. This includes improper medication administration, the sale of or the distribution of any illegal or controlled substances.

6- I will follow the medication directions and not take more than is prescribed unless I call and get permission from Dr. Kovacs, Dr. Ghosh, or John Hubicki, PA-C.

7- I will bring in ALL medication bottles and medications I have left that are written by the Charlotte Pain Management Center to each visit.

It is the <u>STRICT</u> policy of Charlotte Pain Management Center <u>NOT</u> to replace lost or stolen medication.

It is the responsibility of the patient to keep their medication safe from theft or loss. It has been our experience that it is almost always a family member of friend who steals medication. TIP: Never carry all of your meds with you. Get a small-labeled travel bottle from your pharmacy and only carry a days worth of medication in it and lock up the remainder meds in a safe. This way, you never expose ALL of your medication to theft or loss.

NO EARLY REFILLS. Please DO NOT call to move up your appointment if you are not being compliant with your medications. Taking your medication properly is essential to proper management of your pain. Taking more than is prescribed will cause your medications to run out early. IT IS OUR STRICT POLICY NOT TO ALLOW EARLY REFILLS OF MEDICATION DUR TO NON-COMPLIANCE. We do understand that at times you might have more pain. We ask that you call us before you take any extra medication. If you must move your appointment up due to work, vacation or emergency you MUST bring in ALL your medication and have the proper amount of pills left. If you do not have your medication with you…WE WILL SEND YOU BACK TO GET THEM.

By Signing You Agree To Comply With This Agreement.

Signature: _____ **Date:** _____

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DRUG USE QUESTIONNAIRE (DAST-20)

Name: _____ Date: _____

The following questions concern information about your potential involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. In the statements "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) an non-medical use of drugs. The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

		Circle your response	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescriptions drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7.	Do you ever feel bad or guilty about your drug use?	Yes	No
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10.	Have you lost friends because of your use of drugs?	Yes	No
11.	Have you neglected your family because of your use of drugs?	Yes	No
12.	Have you been in trouble at work because of drug abuse?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19.	Have you gone to anyone for help for a drug problem?	Yes	No
20.	Have you been involved in a treatment program specifically related to drug use?	Yes	No

_____ _____

Patient's Signature Date:

_____ _____

Witness Signature Printed Name

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HIPPA PRIVACY CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment and payment of heal care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI) but this must be in writing. Under this law, we have the right to refuse to treat you should you close to refuse to disclose your PHI. If you choose to give consent in the document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Signature _____ Date _____

_____
Patient's printed name

Signature and Description of Personal Representative _____

Witness Name _____ Signature _____ Date _____

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AUTHORIZATION TO DISCLOSE INFORMATION TO A THIRD PERSON

Date: _____

I, _____ authorize _____
Please print patient's name **Name of person to receive information**

My _____, _____
Relationship to the patient **Phone number**

To receive my personal health information on my behalf.

_____ _____
Additional person to receive information **Relationship to patient and phone**

_____ _____
Additional person to receive information **Relationship to patient and phone**

_____ _____
Additional person to receive information **Relationship to patient and phone**

_____ _____
Additional person to receive information **Relationship to patient and phone**

_____ _____ _____
Signature of patient **Date** **Date of Birth**

_____ _____
Witness Signature **Date**