Fast Form: Adult Male
(Please check any corresponding issues)

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weight Gain (Unintentional)
- ☐ Weight Loss (Unintentional)

Eyes
- ☐ Blurred Vision
- ☐ Eye Drainage
- ☐ Eye Pain
- ☐ Glasses/Contacts
- ☐ Sensitivity to Light

Ears/Nose/Throat
- ☐ Ear Pain
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Bleeding Gums
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Thrush

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Pedal Edema

Respiratory
- ☐ Cough (acute)
- ☐ Cough (chronic)
- ☐ Dyspnea
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Anorexia
- ☐ Bloating
- ☐ Dysphagia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Hematuria
- ☐ Hx Frequent UTI's
- ☐ Impotence
- ☐ Urinary Incontinence
- ☐ Urinary Stream Change

Musculoskeletal
- ☐ Joint Stiffness
- ☐ Back Pain
- ☐ Arthralgias
- ☐ Limp Pain
- ☐ Myalgias

Integumentary
- ☐ Pruritis
- ☐ Rashes

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Memory problems
- ☐ Numbness/Tingling
- ☐ Seizures
- ☐ Speech Disorder
- ☐ Tremor
- ☐ Weakness

Hematologic/Lymphatic
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Hx of Blood Transfusions
- ☐ Lymphadenopathy

Endocrine
- ☐ Heat/Cold Intolerance
- ☐ Excessive Sweating

Allergic/Immunologic
- ☐ Seasonal Allergies/"hayfever"

Psychiatric
- ☐ Anxiety
- ☐ Crying Spells
- ☐ Depression
- ☐ Feeling Stressed
- ☐ Personality Change
- ☐ Poor Concentration
- ☐ Recreational Drug Use
- ☐ Sadness
- ☐ Sleep Disturbance
- ☐ Suicidal Thoughts
- ☐ Personality Change
- ☐ Loss of Interest in pleasurable activities

KORUNDA PAIN MANAGEMENT CENTER

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Last Name: _____ First: _____ Middle: _____
Date of Birth: _____ Sex: Female/Male
EMAIL ADDRESS: _____
List other physicians you see: _____
Do you have a living will? Yes/ No Have you designated a health care surrogate? Yes/ No
Name and phone number of surrogate: _____
Have you completed a Do Not Resuscitate Form? Yes/ No Are you an organ donor? Yes/ No
Do you have any Religious or Cultural Practices That may affect your healthcare or treatment? Yes/ No
If yes, in what way? _____
Referring Physician: _____

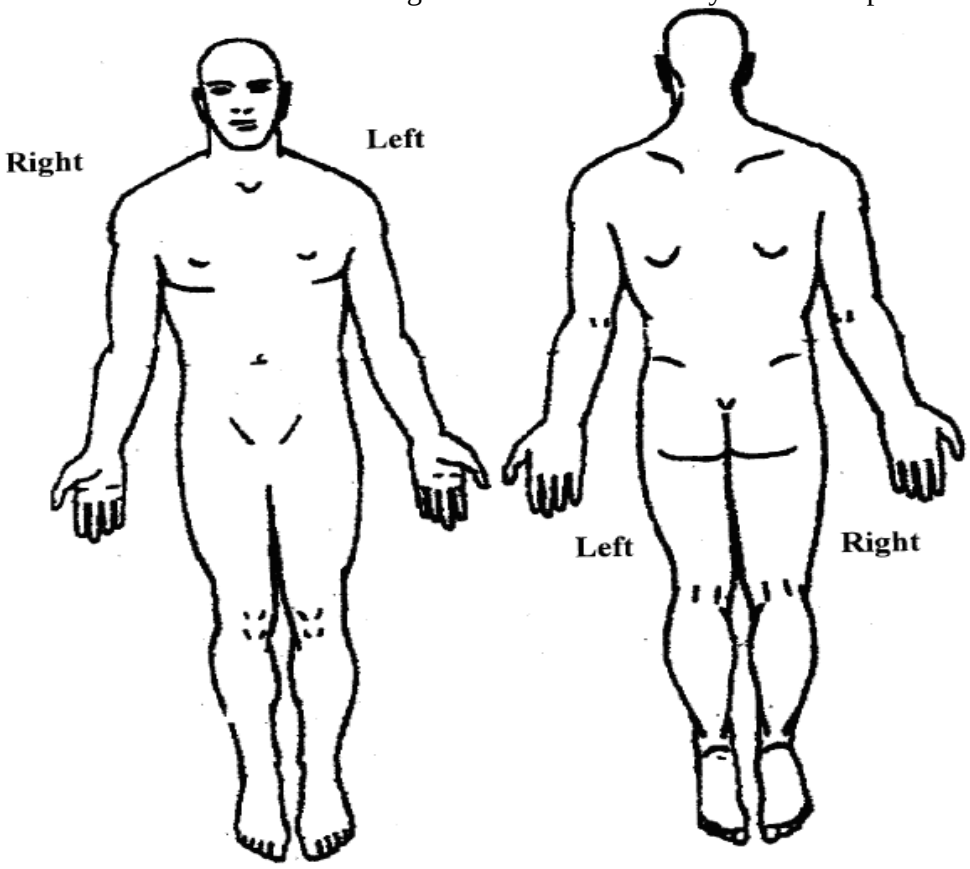
DRUG ALLERGIES/SENSITIVITIES: _____

PLEASE INCLUDE MEDICATIONS- Including non-prescription medications dosage and when taken:

_____
_____
_____

Are you currently taking any blood thinners? Yes/No (Aspirin, Coumadin/Warfarin, Plavix/Clopidogrel, Xarelto, Eliquis, Pradaxa, Lovenox, Brilinta, Pletal, Arixtra) OTHER _____
How long have you been taking this medication? : _____
Why were you put in this medication? : _____
Which doctor is monitoring this medication use? : _____

PAIN HISTORY: Please Shade the areas of the diagram that correlate with your current pain location.



In your own words, describe your pain: _____

Please circle all of the following that describe the character of your pain:
Mild / Moderate / severe Constant / Intermittent
Sharp, Dull, Deep, Superficial, Stabbing, radiating, Tingling, Burning, Aching, Shooting, Spasm, Numbness, and other not listed:

_____
How long have you had this pain? : _____

On a pain scale of 0-10 (0 = none, 10 = worst pain in your life) what is the level today?
1 2 3 4 5 6 7 8 9 10
Is today a typical pain level or is this one of your good/bad days? Good/Bad/Typical
What is your pain level on a bad day, if different from above? 1 2 3 4 5 6 7 8 9 10

Is the pain a result of an injury or trauma? : Yes/No
If so explain: _____

What time of the day is your pain worst? _____ The least? _____
What makes the pain better? _____
What makes the pain worst? _____

TRIED AND OR FAILED MEDICATIONS
Of the following, which medications have you tried for pain relief if any? (Please circle)

NERVE RELATED:
Lyrica/ Cymbalta/ Neurontin

MUSCLE RELAXANTS:
Baclofen/ Flexeril/ Tizanidine/ Skelaxin, Methocarbamol/ Soma

NSAIDS:
Tylenol/Advil/Ibuprofen/Aleve

PATCHES/ GELS:
Lidocaine Patches/ Flector Patches/ Voltaren Gel

IMMEDIATE RELEASE PAIN MEDICATIONS:
Tramadol / Percocet/ Hydrocodone/ Dilaudid / Morphine/ Nucynta

EXTENDED RELEASE PAIN MEDICATIONS:
Oxycontin/ Methadone/ Ms Contin/ Fentanyl

FOR MIGRAINES:
Amitriptyline/ Venlafaxine. Topiramate/ Propranolol/ Metoprolol/ Emgality/Aimovig/ Sumatriptain/ Other Triptains

OTHERS NOT LISTED: _____

IMAGING: Please inform us if you have the results
Do you have copies of the results? Yes/No

MRI Cervical Spine: Yes/ No Date: _____ Facility _____
MRI Thoracic Spine: Yes/ No Date: _____ Facility _____
MRI Lumbar Spine: Yes/ No Date: _____ Facility _____

Other MRI's Yes/ No Body Part: _____Date: _____Facility _____
CT Scans: Yes/ No Body Part: _____Date: _____Facility _____
X-RAY: Yes/ No Body Part: _____Date: _____Facility _____
EMG/NCS: Yes/ No Body Part: _____Date: _____Facility _____

INJECTIONS:
Have you had injections done in the past? Yes/No
Trigger point injections: Yes/No Body location: _____ Dates: _____ Did it help? Yes/No

Joint/Bursa Injections: Yes/No Joint location: _____ Dates: _____ Did it help? Yes/No
Who did the injections? _____

Epidural Injections: Yes/No Cervical/Lumbar/Thoracic Dates: _____ Did it help? Yes/No
Who did the injections? _____

Facet Injections: Yes/No Cervical/Lumbar/Thoracic Dates: _____ Did it help? Yes/No
Who did the injections: _____

Radiofrequency Ablation: Yes/No Cervical/Lumbar/Thoracic Dates: _____ Did it help? Yes/No
Who did the injections? _____

Botox Injections? Yes/No Body location? _____ Dates: _____ Did it help? Yes/No
Who did the injections? _____

CONSERVATIVE TREATMENT:
Have you tried physical therapy? Yes/No Dates/ How many weeks: _____ Did it help? Yes/No
Have you tried Chiropractics/Acupuncture? Yes/No Did it help? Yes/No

SURGICAL HISTORY:

	YEAR		YEAR		YEAR
Cervical Spine □ Laminectomy □ Microdiscectomy □ Fusion □ Other/Unknown:		**Thoracic Spine** □ Laminectomy □ Microdiscectomy □ Fusion □ Other/Unknown:		**Lumbar Spine** □ Laminectomy □ Microdiscectomy □ Fusion □ Other/Unknown:	
□ L/R Shoulder □ Replacement □ Other/Unknown:		□ L/ R Hip □ Replacement □ Other/Unknown:		□ L/R Knee □ Replacement □ Other/Unknown:	
□ L/ R Carpal Tunnel		□ Tonsillectomy/ Adenoids		□ Hernia Repair	
□ L/ R Cataracts		□ Appendectomy		□ Hysterectomy	
□ Pacemaker		□ Gallbladder			
Others:					

MEDICAL HISTORY:

Have you previously had or been suspected to have had:

CARDIAC		**MUSCULOSKELETAL**	
□HYPERTENSION	□IRREGULAR RHYTHM	□RHEUMATOID ARTHRITIS	□GENERALIZED ACHES/PAINS
□HEART ATTACK	□CHEST PAIN	□OSTEOARTHRITIS	□JOINT PAIN
□HEART FAILURE	□PACEMAKER	□FIBROMYALGIA	□MUSCLE ACHES
GASTRO		**ENDOCRINE**	**EARS/NOSE/ THROAT**
□GASTRITIS	□GERD	□DIABETES TYPE I	□DIMINISHED HEARING
□HERNIA	□DIVERTICULITIS	□DIABETES TYPE II	□ALLERGIES
□IBS	□COLITIS	□HYPERTHYROID	□TINNITUS
□HEPATITIS	□LIVER DISEASE	□HYPOTHYROID	□DYSPHAGIA
GU/GYN		**HEMATOLOGY**	**LUNG/ PULMONARY**
□KIDNEY DISEASE	□PROSTATE CANCER	□BLEEDING DISORDER	□ASTHMA
□OVARIAN PROBLEMS	□PROSTATITIS	□SICKLE CELL	□EMPHYSEMA
□DIFFICULTY CONTROLING BLADDER	□ENLARGED PROSTATE	□IMMUNE PROBLEM/ AIDS/ HIV	□COPD
NEUROLOGICAL		**EYES**	**CANCER**
□STROKE	□TIA	□GLAUCOMA	□
□EPILEPSY	□DEPRESSION	□CATARACTS	□

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SOCIAL HISTORY:

Marital Status: MARRIED/ SINGLE/ DIVORCED/ WIDOWED

Do you have any Children? YES/ NO **How many?** _____ **Ages:** _____

Seasonal Resident in _____ or; Full Time resident in _____

Are you currently employed? YES/ NO/ RETIRED/ DISABLED

If yes; where are you employed? _____

If retired; where were you employed? _____

Past employment_____

PERSONAL HABITS (PLEASE CIRCLE)

Do you smoke or have you ever smoked? NO/YES Cigarettes ____ Pipes ____ Cigars ____
How many years? _____ How much per day: _____ Quit date: _____

Do you usually drink over six cups of coffee a day? NO / YES

Do you drink alcohol? YES/NO/PAST HISTORY OF ABUSE
If yes; how often? REGULAR/SOCIAL/RARE
What type of alcohol? HARD LIQUOR/WHITE WINE/RED WINE/BEER

Do you do any Recreational Drugs? YES/NO/PAST HISTORY
If yes; how often? REGULAR/SOCIAL/RARE What types of Drugs? _____

Are you sexually active? YES/NO

History of any of the following: (Please circle) Anxiety (Panic Attacks, acute stress, anxiety due to medication) Major Depression, Bipolar, Suicidal Thoughts, Borderline Personality Disorder, Schizophrenia, NONE, Other:

_____

FAMILY HISTORY

Father: Alive/ Deceased at age _____
Mother: Alive/ Deceased at age _____
Siblings:
Brother/s: # Alive_____ # Deceased _____
Sister/s: # Alive_____ # Deceased _____

PLEASE CHECK IF AN IMMEDIATE FAMILY MEMBER HAS BEEN AFFECTED WITH ANY OF THE FOLLOWING: (EXAMPLE: PARENTS, SIBLINGS, AND CHILDREN)

□ Cancer	□ Diabetes	□ Leukemia	□ Liver Disease
□ Stroke	□ Circulation Problems	□ Heart Disease	□ Bleeding Problems
□ Angina	□ Thyroid Disease	□ Lung Disease	□ Rheumatic Fever/Heart
□ Asthma	□ Colitis	□ Blood Disorders	□ Kidney Disease
□ Allergies	□ Depression	□ Heart Attack	□ Mental Illness
□ Glaucoma	□ Hypertension	□ Kidney Stones	□ Suicide
□ Ulcers	□ Neuromuscular Disease	□ Arthritis	□
□ Migraines	□ Epilepsy/Seizures	□ Tuberculosis	□

PATIENT HEALTH QUESTIONNAIRE-9

(PHQ-9)

Name: _____ Date of Birth: _____ Date: _____

Over the **last 2 weeks**, how often you have been bothered by any of the following problems? **(Please circle your answer)**

Please answer the questions below using the following scale:

0= Not at all, 1= Several days, 2= More than half the days, 3= Nearly every day

1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING **0+_____+_____+_____**

=TOTAL SCORE: _____

If you circles any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
[ ]	[ ]	[ ]	[ ]

Name: _____ Date of Birth: _____ Date: _____

The Alcohol Use Disorders Identification Test: Self-Report Version

Patient: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. **Circle** that best describes your answer to each question.

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking	1-2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have 6 or more drinks in one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor or other healthcare worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
					Total:

Korunda Medical LLC

4513 Executive Drive Naples, FL 34119 Phone (239) 591-2803 Fax (239) 594-5637

Patient Registration

Patient Name: _____ DOB: _____ SSN: _____

Gender: Male [ ] Female [ ] Marital Status: Married [ ] Single [ ] Divorced [ ]

Home Phone: _____ Cell Phone: _____

Email: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

If your billing address is the same as your mailing address please check here [ ]

Billing Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Pharmacy Phone: _____

Address: _____

Patient Demographics

Due to new government regulations, we are required to obtain additional demographic information from our patients. Please fill in the questions below. If you do not wish to disclose this information Please select "declined" from the list of options.

Preferred Language:

- ☐ _____
- ☐ Declined

Race:

- ☐ Asian
- ☐ Hispanic/Latino
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White/Caucasian
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino
- ☐ Refuse to Report

How did you hear about Korunda Medical? _____

KORUNDA MEDICAL, LLC

4513 Executive Dr, Naples, FL 34119

Acknowledgement of Receipt of Notice

I hereby acknowledge that I have received a copy of this Practice's **Notice of Privacy Practices.**

Print Name: _____ Telephone # _____

Signature: _____ Date: _____

If not signed by the patient, please indicate:

Relationship: (please check)

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

For office use only:

Signed form received by: _____ Date: _____

Acknowledgment refused:

- ☐ Yes
- ☐ No

Efforts to obtain: _____

Reason for refusal: _____

KORUNDA MEDICAL, LLC (F-2)

Consent for Purpose of Treatment, Payment or Health Care Operations

I consent to the use or disclosure of my protected health information by Korunda Medical, LLC. For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Korunda Medical LLC.

I understand that diagnosing or treatment of me by Korunda Medical, LLC may be conditioned upon my consent as evidence by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Korunda Medical, LLC agrees to a restriction that I request, the restriction is binding on the practice.

I have the right to revoke this Consent, in writing, at any time, except to the extent that action has been taken in reliance on this Consent.

My "Protected Health Information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Korunda Medical, LLC's Notice of Privacy Practices prior signing this document.

Korunda Medical, LLC Notice of Privacy Practices has been provided to me:

The Notice of Privacy Practices for Korunda Medical, LLC describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of heath care operations.

A summary of the Notice of Privacy Practices for Korunda Medical, LLC I also posted in the waiting room.

The Notice of Privacy Practices also describes my rights and duties of Korunda Medical, LLC with respect to my protected health information.

Korunda Medical, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by contacting Korunda Medical, LLC at 4513 Executive Drive Naples, FL 34119.

_____ _____

Patient Name (please print) **Date**

_____

Signature of Patient or Representative

_____ _____

Name of Patient or Representative (please print) **Employee Initial**

Korunda Medical, LLC.

FINANCIAL POLICY

Thank you for choosing Korunda Medical as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Part of this good practice is to provide you with a clear understanding of our financial policy.

CO-PAYS/DEDUCTIBLES/ CO-INSURANCE

Payments are due at time of check-in unless previous arrangements have been made with the billing department. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. Payments include all co-pays, deductibles, co-insurance and non-covered charges along with any past due balances. In addition, payment in full must be made if you do not have insurance, or if your coverage is currently under a pre-existing condition clause.

MEDICARE PART B

All Physicians/Providers at Korunda Medical, LLC are participating providers with Medicare Part B. Please be aware that Medicare has an annual deductible at the beginning of every year. After your deductible has been met, Medicare only pays for 80% of allowed charges. You will be responsible for the deductible and for the remaining 20% co-insurance. If you have supplemental insurance, it is your responsibility to provide us with that information. **Any remaining balance after payment from Medicare and the supplement insurance will be your responsibility.**

INSURANCE

Insurance is a contract between you and your insurance company. As a courtesy to you we will bill your primary insurance company. We are required to collect all co-pays, deductibles and coinsurance due to our contracts with your insurance. It is your responsibility to provide us with all your insurance information both primary and secondary or any changes made to your insurance. Failure to do so may result in patient responsibility in full.

Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by your insurance.

WORKER'S COMPENSATION

If you have a worker compensation claim, it is your responsibility to provide us with any/all necessary billing information prior to your first visit. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. Once the worker's compensation carrier has released you from its financial responsibility or if benefits are denied, you will be responsible to pay in full for services rendered. Please understand that worker's compensation requires prior authorization for each office visit and/or procedure.

PERSONAL INJURY OR MOTOR VEHICLE ACCIDENT

As a courtesy, this facility will bill your MVA Insurance once you have provided us with all the necessary billing information for your claim. If this information is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service. Due to extreme delays of payment associated with such cases, Korunda Medical LLC., regrets to inform you that we do not accept letters of protection.

FORMS/MEDICAL RECORDS FEES

There will be a fee for all forms, copies of medical records, notarizing and for extra written communication by the doctor. If you are requesting copies of medical records a request must be made and our billing department will contact you with the fee. We require pre-payment for these services. The charge is determined by the complexity of the form, letter or communication. Please keep in mind completing these tasks require office staff time and time away from patient care for our doctors.

RETURNED CHECKS/CREDIT CARD PAYMENTS

Returned checks will incur a service charge. You will be asked to bring cash for any future visits if this occurs. All bad checks written to this office are subject to collections. Stopped payments for either checks or credit card constitute a breach of payment and are subject to a service fee and collections action.

ACCOUNTING PRINCIPALS

Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

COLLECTION FEES

In the event that your account is placed in a collections status, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of up to 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts. You may also be responsible for up to 1.5% interest per month. Please understand that these additional fees will be your personal responsibility to pay in full.

PATIENT NO-SHOW/CANCELLATION POLICY

Korunda Medical, LLC., requires a minimum of 24-hour notice for any canceled appointment. Failure to give proper notice in advance or not keeping your appointment for any reason resulting as a "no show" will be assessed a $25.00 fee. This fee will not be paid by your insurance company. You are responsible to pay this fee immediately. Thank you for your cooperation.

I have read and understood the practices financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Print Patient Name

Signature of Patient and/or Responsible Party Date

KORUNDA MEDICAL, LLC

4513 Executive Dr, Naples, FL 34119
Phone: (239) 591-2803
Fax: (239) 594-5637

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient: _____ Date of Birth: _____

I authorize the following people to speak freely with both Doctor and nurse about my medical conditions. Authorization includes the following information:

- Medication
- Past medical history
- Present care
- Future plan of care
- Appointments
- Billing and payments

Contact person: _____ Relationship: _____

Contact number: _____

Contact person: _____ Relationship: _____

Contact number: _____

Contact person: _____ Relationship: _____

Contact number: _____

☐ **I DENY THE AUTHORITY TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN MYSELF.**

By signing this form I authorize OR deny the following people to obtain information about me and my medical care with Korunda Medical Institute.

Signature: _____ Date: _____

Witness: _____ Date: _____

KORUNDA PAIN MANAGEMENT CENTER

4513 Executive Drive, Naples, FL 34119 Phone: (239) 591-2803 Fax: (239) 594-5637

Authorization to Release or Obtain Medical Records

Date: ___/___/___

Patient Name: _____ DOB: ___/___/___

I authorize the use/disclosure of health information about me as described below from:

_____

_____

_____

Release to:

_____

☐ **Complete Medical Records** ☐ **X Ray and Imaging Reports** ☐ **Progress Notes**

☐ **Other (please specify)** _____

It is my intent that information furnished is prohibited for any purpose other than that state above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose above.

I understand I may revoke this consent at any time before the information has been released. A copy of this authorization will be accepted as the original.

I release the organization complying with this request of all responsibility for loss of confidentiality by access and/or copies of records released in compliance to this authorization.

I further direct that information from prior to the date of my signature will be honored; this request will expire after a period of 3 years from the date below; and that a photocopy of this authorization be granted the same as the original.

_____ Date: _____

Signature of Patient (If signed by another person other the patient, state the relationship and authority to do so.)
Legal Authority is: ☐Power of Attorney ☐Authorized Legal Representative

_____ Date: _____

Signature of Witness

Pursuant to Florida statutes, there will be a charge for medical records copied and released to patients. There is no charge for copies to physicians for continuation of care.