Reset Form

PRIMARY CARE
AT MEDICAL CENTER CLINIC

Primary Care at Medical Center Clinic would like to welcome you to our practice! It is our goal to be the premier provider of compassionate, quality healthcare by providing our patients with exceptional service with integrity.

Please arrive 15 minutes prior to your appointment time.

Remember to bring all valid insurance card(s) and photo identification to each visit, as they are required to verify identity and update any changes. If you are unable to make your scheduled appointment, please contact our office at 850.474.8200 within **48 hours**, as we have reserved this time slot just for you.

A review of your medications will be an important part of your annual and routine exams. Please bring a complete list of medications with you to each appointment. This includes all over-the-counter medications and supplements.

On-going narcotic medication(s) will not be prescribed in our practice.

For your convenience, we accept requests for prescription refills during office hours. Please contact your pharmacy to initiate a prescription refill. Requests will be responded to within 48 hours with the exception of weekends or holidays.

We have highly skilled advanced practice clinicians who, in conjunction with our physicians, may provide healthcare to you. Our advanced practice clinicians are available for same-day appointments to care for acute medical conditions.

Our office hours are:

Day	Time
Monday	7:00 AM – 4:00 PM
Tuesday	7:00 AM – 4:00 PM
Wednesday	7:00 AM – 4:00 PM
Thursday	7:00 AM – 4:00 PM
Friday	7:00 AM – 4:00 PM

We appreciate your assistance in these matters and we look forward to serving you. If you have any questions, concerns or suggestions please feel free to contact us at 850.474.8200.

Sincerely,
Primary Care at Medical Center Clinic

8333 North Davis Highway • Pensacola, FL • 32514
FAX: 850.474.8016 • PHONE: 850.474.8200


Vivid Pathology
Quest Diagnostics
Diagnostic Center
Doctors Call Center
Gulf Region Postal Center
SleepDiagnostic CENTER
Release of Information
The Urology Center
Courtyard Café
VCS
ATM
DERMATOLOGY & LASERCENTER
WELCH
Walgreens
AT THE CORNER OF HAPPY & HEALTH
BUBBLEWALL
To Elevator
DaVita
STOP
STOP

PRIMARY CARE
AT MEDICAL CENTER CLINIC

Signature Check List

Enclosed are several forms for your review and signature. Below is a checklist to aid in your completion of these forms. Please bring all forms with you to your scheduled appointment.

☐ **1.** Welcome Letter – *no signature required*

☐ **2.** Notice of Health Information Privacy Practices – *no signature required*

☐ **3.** Patient Insurance Assignment & Responsibilities Acknowledgment

a. Review and initial Consent to Treatment section

b. Review and initial Lifetime Insurance Assignment section

c. Review and initial Patient Financial Responsibility Policy section

d. Review and initial Tobacco-Free Camp

e. Sign and Date bottom of form

☐ **4.** HIPAA Acknowledgement Form

a. Print Name, Sign and Date

☐ **5.** Priority Care Health History Form

a. Complete entire form to best of your knowledge and bring to your appointment

b. Complete all sections

c. Review and sign

8333 North Davis Highway • Pensacola, FL • 32514
FAX: 850.474.8016 • PHONE: 850.474.8200

Notice of Health Information Privacy Practices

Effective September 23, 2013

This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Thank you for choosing the Medical Center Clinic for your healthcare needs. Each time you visit one of our providers, we create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of your records of your care received by a provider at Medical Center Clinic and explains how we may use and disclose your health information as well as your rights regarding the health information we maintain about you.

We are required by law to make sure that health information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this Notice at any time.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

Treatment: We will use and disclose your health information to provided medical treatment to you, and to coordinate or manage your health care related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose your health information when you need a prescription, lab work, an x-ray or other health care services. Also, we may use and disclose your health information when referring you to another health care provider.

Payment: We may use and disclose your health information to bill and receive payment. For example: A bill may be sent to you or your insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Operations: We may use and disclose health information about you for health care operations. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including compliance program activities and business planning.

Business Associates: We may disclose your health information to our Business Associates to carry out treatment, payment or health care operations. For example, we may disclose health information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the services we provide.

Appointment Reminders, Treatment Alternatives or Health-Related Services: We may contact you to provide appointment reminders, tell you about health-related services, to recommend possible treatment options or alternatives that may be of interest to you.

Research: We may use and disclose information to researchers or to collect information in databases used for research. Research projects are reviewed and approved by a Review Board to protect the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to ad-verse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Military and Veterans: If you are a member of the armed forces, or separated or discharged from the military services, we may disclose your health information as required by national military command authorities or the Department of Veterans Affairs.

Public Health: We may disclose your health information to a public health authority that is permitted by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary to provide you with healthcare; to protect your health and

safety or the health and safety of other individuals; or for the safety and security of the correctional institution.

Law Enforcement: We may disclose health information in response to a valid subpoena, warrant, summons or similar process. We may also release information for purposes of locating a suspect, a fugitive, a material witness, or missing person.

Health Oversight Activities: Federal law makes provisions for your health information to be released to an appropriate health oversight agency for activities such as audits, investigations, and inspections. This includes government agencies that oversee the healthcare system, government benefit programs, other government regulatory pro-grams, and the civil rights laws.

SPECIAL CIRCUMSTANCES

Florida Privacy Laws: Health information related to substance abuse, mental health, or sexually transmissible diseases have special privacy protections in Florida. We will not disclose health information relating to substance abuse, mental health, or sexually transmissible disease unless: 1) the patient consents in writing, or 2) a court order requires disclosure of the information, or 3) medical personnel need information to meet a medical emergency, or 4) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits or program evaluation, or 5) it is necessary to report a crime or a threat to commit a crime, or 6) to report abuse or neglect as required by law.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or law that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights with respect to your health information:

Right to Inspect and Copy Your Health Information: You have the right to see and obtain copies of health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

Right to Amend: If you think that health information we have about you is incorrect or incomplete, you may ask us to correct or add to the information, but we are not required to agree to the requested amendments.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your protected health information.

Right to Request Restrictions: You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment or health care operations, but we are not required to agree to the requested restrictions.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to your health plan for purposes of carrying out payment or your health plan's operations; and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to Breach Notification: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to Obtain a Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

QUESTIONS OR COMPLAINTS

If you have questions about this Notice, or believe that your privacy rights have been violated, please contact Corporate Compliance and Privacy Officer toll free at 1-866-822-3571, by e-mail at privacy.officer@medicalcenterclinic.com, or by U.S. Mail at:

Medical Center Clinic
Attn: Corporate Compliance and Privacy Officer
8333 N. Davis Hwy
Pensacola, FL 32514

You have the right to file a written 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.

PLACE LABEL OR PRINT PATIENT INFORMATION BELOW

MCC No.:

Patient First and Last Name:

Patient DOB:

Date of Service:

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

PATIENT INSURANCE ASSIGNMENT & RESPONSIBILITIES ACKNOWLEDGEMENT

Please read and initial each section and sign acknowledgement below:

Consent to Treatment: I consent to care, treatment, testing, and all other services performed by healthcare providers at Medical Center Clinic. I understand that I have the right to refuse any proposed care, treatment, testing, surgery, or other procedure. I understand that I have the right to ask questions and discuss my care with my healthcare provider. **Initials of Patient or Legal Representative:** _____.

Lifetime Insurance Assignment: I hereby instruct and direct my past and/or present insurance company to issue payment directly to:

West Florida Medical Center Clinic, P.A.
8333 North Davis Highway
Pensacola, FL 32514

for all medical, surgical, and diagnostic expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to MCC and I agree to pay, within sixty (60) days of the date of the first monthly bill, any balance of said charges over and above this insurance payment, including applicable copayments, deductible, non-covered services and items, unauthorized services or any fees denied, except to the extent my liability for any such balance is limited by agreement or law applicable to MCC. A photocopy of this assignment shall be considered as effective and as valid as the original. Furthermore, I understand that 1) MCC accepts Medicare assignment and Medicare payments will be directed to MCC and 2) Medical Center Clinic does not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim and any account balance not paid in full within sixty (60) days of the date of the first monthly bill is considered delinquent. I agree to pay reasonable attorney's fees and collection expenses should my account be referred for collection procedures. **Initials of Patient or Legal Representative:** _____.

Patient Financial Responsibility Policy: Co-payments, deductibles, co-insurance, and all other appropriate payment will be due at time services are rendered. Insurance companies require physician offices to collect all applicable patient portions prior to services being rendered. **Initials of Patient or Legal Representative:** _____.

Tobacco-Free Campus: Use or sale of tobacco products (cigarettes, including electronic; cigars; pipes; and smokeless tobacco) is prohibited on all Medical Center Clinic premises, campuses, parking lots and grounds. **Initials of Patient or Legal Representative:** _____.

I acknowledge and understand the above notices and assignments and will comply with all specified responsibilities.

_____ _____
Signature of Patient or Legal Representative Date

PLACE LABEL OR PRINT PATIENT INFORMATION BELOW

MCC No.: _____

Patient First and Last Name: _____

Patient DOB: _____

Date of Service: _____

Medical Center Clinic℠
HEALTHCARE CENTERED AROUND YOU

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

Thank you for choosing Medical Center Clinic for your health care needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices ("Notice"). To ensure that our records are accurate, please sign below to acknowledge that you have been provided with a copy of our Notice.

_____ _____
Patient Signature Date of Signature

PERSONAL REPRESENTATIVE

Complete this section ONLY if you are signing this Notice of Privacy Practices as the patient's personal representative i.e., parent of minor child, power of attorney, health care surrogate, legal guardian.

_____
Personal Representative (Print Name)

_____ _____
Personal Representative Signature Date of Signature

OFFICE USE ONLY

A good faith attempt was made to obtain the patient's written acknowledgement of receipt of MCC's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual declined to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please describe below)

_____ _____
Employee Name (please print) Date

PRIMARY CARE
AT MEDICAL CENTER CLINIC

Health History Form

Please fill out health history form to the best of your ability and bring to your first appointment.

Name: _____ MCC#

Age: _____ Date of Birth: _____

Date of visit:
REASON FOR TODAY'S APPOINTMENT:

HEALTH CARE PROVIDERS IN PAST 5 YEARS:

Name	Physician Specialty	Are you still seeing?
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

PERSONAL MEDICAL HISTORY: Have you ever been treated for or been told you have any of the following:

Condition	Yes	No
Angina	☐	☐
High Blood Pressure	☐	☐
Heart Failure	☐	☐
Heart Attack	☐	☐
High Cholesterol	☐	☐
Heart Disease	☐	☐
Pacemaker	☐	☐
Peripheral Vascular Disease	☐	☐
Migraines	☐	☐
Kidney Stones	☐	☐
Kidney Disease	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Cancer Type: _____	☐	☐
Osteoporosis	☐	☐
Asthma	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Stroke/TIA	☐	☐
Seizure	☐	☐
Sleep Apnea	☐	☐

Condition	Yes	No
Seasonal Allergies	☐	☐
Bleeding Disorder	☐	☐
Blood Clots	☐	☐
Anemia	☐	☐
Diabetes	☐	☐
Arthritis	☐	☐
Lupus	☐	☐
Fibromyalgia	☐	☐
Liver Disease	☐	☐
Chronic Constipation	☐	☐
Acid Reflux/GERD	☐	☐
Colon Polyps	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Drug Abuse	☐	☐
Alzheimer's/Dementia	☐	☐
Thyroid Disease	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Genetic Disorder	☐	☐
Other: _____	☐	☐

SURGERIES: (Please include date)

- ☐ Appendectomy (Date:_____)
- ☐ Gallbladder Removal (Date:_____)
- ☐ Hip Replacement - ☐ Right ☐ Left (Date:_____)
- ☐ Hysterectomy (Date:_____)

HOSPITALIZATIONS:

(1) _____
(2) _____
(3) _____
(4) _____

☐ Cataracts - ☐ Right ☐ Left (Date:_____)
☐ Knee Replacement - ☐ Right ☐ Left (Date:_____)
☐ Stents (Date:_____)
☐ Other: _____

(5) _____
(6) _____
(7) _____
(8) _____

INFECTIOUS DISEASES: Have you ever been treated for or been told you have any of the following:

	Yes	No			Yes	No	
Hepatitis	○	○		HIV/AIDS	○	○	
Frequent UTIs	○	○		Tuberculosis	○	○	
MRSA	○	○	If yes, where? _____	VRE	○	○	If yes, where? _____

HEALTH MAINTENANCE:

Lipid(cholesterol) ○ Yes ○ No Date:_____ Abnormal? ○ Yes ○ No
Colonoscopy ○ Yes ○ No Date:_____ Abnormal? ○ Yes ○ No Were any polyps removed? ○ Yes ○ No
Mammogram ○ Yes ○ No Date:_____ Ever had an abnormal result? ○ Yes ○ No If so, when?_____
Pap Smear ○ Yes ○ No Date:_____ Ever had an abnormal result? ○ Yes ○ No If so, when?_____
DEXA scan /Bone scan ○ Yes ○ No Date: _____ Abnormal? ○ Yes ○ No
PSA (prostate) ○ Yes ○ No Date:_____ Abnormal? ○ Yes ○ No

VACCINATION HISTORY: (Please provide date of last vaccination)
Tetanus: _____ Tuberculin Skin Test: _____ Pneumonia: _____ Influenza: _____ Shingles:_____

ALLERGIES: (please list type of allergies and describe the reaction you experienced)

(1)_____ Reaction: _____
(2)_____ Reaction: _____
(3)_____ Reaction: _____
(4)_____ Reaction: _____
(5)_____ Reaction: _____
(6)_____ Reaction: _____
(7)_____ Reaction: _____
(8)_____ Reaction: _____

SOCIAL HISTORY:

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Significant Other

Highest Level of Education:

☐ _____ Grade ☐ High School ☐ Some College ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate

Occupation:

Work Status: ○ Retired ○ Full Time ○ Disabled ○ Unemployed
Occupation: _____

Living Arrangements:

○ Alone ○ With Spouse ○ With Spouse and Children ○ With Children ○ With Father ○ With Mother ○ With Parents ○ With Guardian

Travel:

Have you traveled outside the USA in the last year? ○ Yes ○ No If yes, where?_____

Tobacco Use:

☐ Non-Smoker (Never Smoked) ☐ Ex-Smoker (Year Quit? _____) ☐ Current Smoker (Packs per day? _____)

Alcohol Use:

☐ Never ☐ Occasional (how often?_____) ☐ Frequent (# of drinks/week? _____)
Is your alcohol use a concern for you or others? ○ Yes ○ No

Caffeine Use:

How much caffeine do you consume each day?_____

Drug Use:

Do you use any recreational drugs? ○ Yes ○ No If yes, what types?_____

Exercise Frequency

○ Never ○ 2-3 times/week ○ 4-5 times/week ○ Daily
How long does your work-out usually last? _____ What types of exercises do you perform?_____

WOMAN'S HEALTH HISTORY:

Age at onset of menstruation: _____ Date of last period: _____ Age of menopause: _____

Could you be pregnant? ◯ Yes ◯ No Menstrual cycle: _____ days Usual duration of flow: _____ days

Cycle: ◯ Regular ◯ Irregular Flow: ◯ Heavy ◯ Medium ◯ Light Cramps: ◯ Severe ◯ Mild ◯ None

Pregnancies: How many? _____ Children born alive? _____ Stillbirths? _____ Abortions? _____ Miscarriages? _____

REVIEW OF SYSTEMS: (Please check any symptom you are currently experiencing)

Constitutional
- ☐ Recent fevers
- ☐ Night sweats
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Unexplained fatigue
- ☐ Unexplained weakness

Eyes
- ☐ Change in vision

Ears/Nose/Throat/Mouth
- ☐ Difficulty hearing
- ☐ Ringing in ears
- ☐ Hay fever
- ☐ Allergies
- ☐ Persistent congestion
- ☐ Trouble swallowing

Cardiovascular
- ☐ Chest pain
- ☐ Chest pressure
- ☐ Palpitations
- ☐ Short of breath with exertion

Respiratory
- ☐ Cough
- ☐ Wheeze
- ☐ Coughing up blood
- ☐ Coughing up mucus

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Recent back pain

Skin
- ☐ Rash
- ☐ New mole
- ☐ Change in mole

Blood/Lymphatic
- ☐ Unexplained lumps
- ☐ Easy bruising
- ☐ Easy bleeding

Breast
- ☐ Breast lump
- ☐ Nipple discharge

Gastrointestinal
- ☐ Recent heartburn/reflux
- ☐ Blood in stool
- ☐ Change in bowel movement
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Frequent constipation

Genitourinary
- ☐ Painful urination
- ☐ Bloody urination
- ☐ Leaking urine
- ☐ Frequent nighttime urination
- ☐ Discharge from penis or vagina
- ☐ Concerns with sexual functions

Neurological
- ☐ Headaches
- ☐ Memory loss
- ☐ Fainting

Psychiatric
- ☐ Anxiety
- ☐ Stress
- ☐ Sleeping problems
- ☐ Unusual sadness
- ☐ Unusual crying

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Increased thirst
- ☐ Increased appetite

Other Symptoms/Concerns

_____

_____

_____

-CONTINUED ON NEXT PAGE-

FAMILY HISTORY: Indicate which relative has had the following

☐ **Adopted, unknown family**

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other Relative	Comments
No significant history known	☐	☐	☐	☐	☐	☐	☐	☐		
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐		
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐		
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney Failure	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐		
Hepatitis B	☐	☐	☐	☐	☐	☐	☐	☐		
Hepatitis C	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer (Breast)	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer (Colon)	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer (Ovarian)	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer (Prostate)	☐	☐	☐	☐	☐	☐	☐	☐		
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐		
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐		
Bleeding/Clotting Disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐		
Lupus	☐	☐	☐	☐	☐	☐	☐	☐		
Colon Polyp	☐	☐	☐	☐	☐	☐	☐	☐		
Depression	☐	☐	☐	☐	☐	☐	☐	☐		
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐		
Alzheimer's	☐	☐	☐	☐	☐	☐	☐	☐		
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐		
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐	☐		
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐		
Macular Degeneration	☐	☐	☐	☐	☐	☐	☐	☐		
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Hip Fracture	☐	☐	☐	☐	☐	☐	☐	☐		
Other (please list)										

8333 North Davis Highway • Pensacola, FL • 32514
FAX: 850.474.8016 • PHONE: 850.474.8200

MEDICATIONS: (Please list all medications that you are now taking, strength and how often you take each)

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Medication: _____ Strength: _____ Frequency: _____

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____

8333 North Davis Highway • Pensacola, FL • 32514
FAX: 850.474.8016 • PHONE: 850.474.8200

PRIMARY CARE
AT MEDICAL CENTER CLINIC

PHI Disclosure / Release

PLEASE FILL OUT FORM COMPLETELY

Patient Information:

Patient Name: _____ Medical Record #_____ Date of visit: _____

Date of Birth:_____ Last Four Digits of SS: XXX-XX- _____ Phone Number: _____

I hereby authorize _____to release the following information

contained in my medical record for treatment during the period from _____ to

_____ as follows:

☐ **All records *including* Confidential** ☐ **All records *except* Confidential**

Confidential:

☐ Mental Health ☐ Sexually Transmissible Disease(s) ☐ Substance Abuse ☐ Genetic Testing

Treatment Records:

☐ All Patient Health Information ☐ Progress notes for Doctors ☐ Lab Reports ☐ X-ray Reports

☐ Other (*Please Specify*) _____

Disclosure of patient's PHI TO: Alison Ray, APRN-C

8333 N. Davis Hwy
Pensacola, FL 32514
Ph: 850.474.8200 Fax: 850.969.2297

_____ (INITIAL) I acknowledge that the records requested above may contain alcohol, drug abuse, mental health, sexually transmissible disease(s) (including HIV and AIDS), and genetic information, and hereby consent to the disclosure of said information.

Expiration: This Authorization shall expire automatically one (1) year from date signed or upon:

☐ Fulfillment of this request (according to HIPAA or State Regulations, whichever is shorter.)

☐ Specific Date: _____

☐ Yes ☐ No This authorization may be used to disclose PHI of the same type described above which may be created in the future until the expiration date.

I understand that by federal law, Medical Center Clinic (MCC) may not use or disclose PHI without authorization except as provided in MCC's Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosure of the described PHI. I hereby release MCC and its employees from any and all liability that may arise from the release of information as I directed.

- I understand that I have the right to revoke this Authorization at any time if I do so in writing and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

- I understand that I may refuse to sign this Authorization and that MCC and/or the providers named above cannot deny or refuse to provide treatment if I refuse to sign.

- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

- I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

_____ _____

Patient/Legal Representative Signature **Date**

If signed by Legal Representative:

Relationship to Patient: _____ Legal Authority: _____

Verification of Identity: _____ Verification of Authority: _____