ELIAS A. FEANNY, M.D., P.A.

CORAL REEF MEDICAL BUILDING PARK 2

9275 SW 152ND STREET #101 MIAMI, FL. 33157

PHONE (305)2538869 FAX (305)2339726

DATE: _____

ALLERGIES: _____

PATIENT INFORMATION

Name: _____ *SSN#* _____-_____-_____

(First) (Middle) (Last)

Date of Birth: _____/_____/_____ *Age:* _____ *Marital Status:* _____

(MM) (DD) (YYYY) (S/M/D/W)

Permanent Address: _____

City: _____ *State:* _____ *Zip Code:* _____

Telephone Number: HOME: (_____) _____ *CELL (____)* _____

*E-MAIL ADRESS :*_____

Occupation: _____ *Employer/School* _____

Business Address: _____

City: _____ *State:* _____ *Zip Code:* _____ *Tel. Num. (____)_____-_____*

RELATIVE INFORMATION / EMERGENCY CONTACT

Relative Name: _____ *Relation:* _____

Address: _____

City: _____ *State:* _____ *Zip Code:* _____

Telephone Number: HOME: (_____) _____ *CELL (____)* _____

INSURANCE INFORMATION

Name of Insurance Co: _____ *Phone: (____)* _____-_____

Contract, Policy, or ID NO: _____ *Group #* _____

Is this Insurance an HMO or PPO? Yes _____ *NO* _____

Do you have other Insurance? Yes _____ *NO* _____

X_____

PLEASE SIGN HERE

ELIAS A. FEANNY, M.D., P.A.
CORAL REEF MEDICAL BUILDING PARK 2
9275 SW 152ND STREET #101 MIAMI, FL. 33157
PHONE (305)2538869 FAX (305)2339726

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

To: _____

Phone: _____ *Fax:* _____

I hereby authorize you to release records to:

ELIAS A. FEANNY, M.D., P.A.
CORAL REEF MEDICAL BUILDING PARK 2
9275 SW 152ND STREET #101 MIAMI, FL. 33157
PHONE (305)2538869 FAX (305)2339726

Copies of my medical records in you possession, concerning my illness and / or my treatment, as indicated below:

_____

Dates of Service: _____

Please indicate if the records (MAY INCLUDE) the following:

YES ____ NO ____ Psychiatric or mental health illness
YES ____ NO ____ Drug and alcohol abuse records
YES ____ NO ____ HIV, AIDS Test/Diagnosis, or related conditions
YES ____ NO ____ (Women) Abortion records

I release Dr. Elias A. Feanny M.D., P.A. of all responsibility for loss of confidentiality access and / or copies of records released in compliance with this authorization.

Patient Name: _____
Address: _____
Date of Birth: _____ ***SS#***_____

Patient Signature: _____ ***Date:*** _____

Witness Signature: _____ ***Date:*** _____

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Authorization to Use or Disclose My Health Information

Patient Name: _____ *Date:* _____
Previous Name: _____

1. ***My Authorization***

You may use or disclose the following health care information (check all that applies):

- o *All my health information maintained by the above-named practice*
- o *My health information relating to the following treatment or condition:* _____
- o *My health information for the date(s):* _____
- o *Other:* _____

You may disclose this health information to:

Name (or title) and organization: _____
Address: _____ *City* _____ *State:* _____ *Zip:* _____

Reason(s) for this authorization (check all that apply):

- o *At my request*
- o *Other (specify)* _____

This authorization ends:

- o *On (date)* _____
- o *When the following event occurs* _____

2. ***My Rights***

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- ➢ *Fill out a revocation form. The form is available from the office.*

~ or ~

- ➢ *Write a letter to the office.*

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature: _____ ***Date:*** _____