**DEVEN MEDICAL CENTER**

WEST FLORIDA MEDICAL ASSOCIATES, PA

**Ulhas T. Deven, M.D.** 11707 N. Williams Street 41 N Inglis AveBOARD CERTIFIED INTERNAL MEDICINE Dunnellon, FL 34432 Inglis, FL 34449 **Elizabeth Pike, ARNP-C** Phone : (352) 465-1919 Phone: (352) 447-2122
BOARD CERTIFIED FAMILY NURSE PRACTITIONER Fax: (352) 465-7576

**Samantha Kreisle, ARNP-C**

BOARD CERTIFIED FAMILY NURSE PRACTITIONER

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DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: (\_\_\_\_\_\_\_)--\_\_\_\_\_\_\_\_\_--\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_**--**\_\_\_\_\_\_\_**\_--**\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT: *NAME, RELATION, ADDRESS & PHONE* # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LOCATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DID YOU HEAR ABOUT US? *CIRCLE ONE* YELLOW PAGES, INTERNET, BILLBOARD, OR OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RACE ETHNICITY LANGUAGE**

\_\_\_\_\_ WHITE \_\_\_\_\_ NON-HISPANIC \_\_\_\_\_ ENGLISH

\_\_\_\_\_ AFRICAN AMERICAN \_\_\_\_\_ HISPANIC \_\_\_\_\_ SPANISH

\_\_\_\_\_ ASIAN \_\_\_\_\_ UNKNOWN \_\_\_\_\_ INDIAN

\_\_\_\_\_ NATIVE AMERICAN/ESKIMO \_\_\_\_\_ OTHER

\_\_\_\_\_ PACIFIC ISLANDER/NATIVE HAWAII

\_\_\_\_\_ OTHER

\_\_\_\_\_ UNKNOWN

**ADVANCED DIRECTIVES**

(*FOR COMPLIANCE WITH THE PATIENT SELF-DETERMINATION ACT OF FLORIDA STAUTES CHAPTER 765*)

\*HAVE YOU EXECUTED AN ADVANCED DIRECTIVE? YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF YES, IS THIS DIRECTIVE IN THE FORM OF:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A LIVING WILL

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A DURABLE POWER OF ATTORNEY

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ A HEALTH CARE SURROGATE

\*HAVE YOU PROVIDED THIS OFFICE WITH A COPY OF ADVANCED DIRECTIVE? YES \_\_\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_\_

IF YOU WOULD LIKE MORE INFORMATION REGARDING ADVANCED DIRECTIVES PLEASE ASK THE NURSE OR RECEPTIONIST.

***I HAVE BEEN PROVIDED WITH INFORMATION REGARDING THE “PATIENT SELF-DETERMINATION ACT”***

\***SIGNATURE OF PATIENT OR REPRESENTATIVE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

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**Samantha Kreisle, ARNP-C**

BOARD CERTIFIED FAMILY NURSE PRACTITIONER

**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU ALLERGIC TO ANY MEDICATIONS**? \_\_\_\_\_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_\_\_\_\_\_NO

 IF YES, PLEASE LIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST OF MEDICATION (If longer, please attach a list with this form)**

**NAME DOSAGE FREQUENCY**

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**MEDICAL HISTORY:** Please check each one that applies.

  **SELF MOTHER FATHER**

LIVING X \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

DECEASED X \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

DIABETES \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

HYPERTENSION \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

HEART DISEASE \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

STROKE \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

MENTAL ILLNESS \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

CANCER \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

COPD \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

EMPHYSEMA \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

ALZHEIMERS \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

OTHERS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SMOKE CIGARETTES? Non-smoker \_\_\_\_\_\_\_ former smoker \_\_\_\_\_\_ current smoker \_\_\_\_\_\_\_

 IF YES, HOW MANY DAILY: \_\_\_\_\_\_\_\_ LESS THAN ONE PACK \_\_\_\_\_\_\_\_\_\_ ONE PACK \_\_\_\_\_\_\_ MORE THAN ONE PACK

SMOKELESS TOBACCO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_\_\_\_\_ NO

DO YOU USE ANY RECREATIONAL DRUGS? \_\_\_\_\_\_\_\_\_\_\_\_ YES \_\_\_\_\_\_\_\_\_\_\_\_NO

DO YOU DRINK ALCOHOLIC BEVERAGES? \_\_\_\_\_ NEVER \_\_\_\_\_MONTHLY OR LESS \_\_\_\_\_ 2 TO 4 TIMES A MONTH

 \_\_\_\_\_ 2 TO 3 TIMES A WEEK \_\_\_\_\_ 4 OR MORE TIMES A WEEK

**SURGICAL HISTORY**

HAVE YOU EVER HAD SURGERY? \_\_\_\_\_\_\_\_YES \_\_\_\_\_\_\_\_\_NO

IF YES, LIST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## PATIENT ACKNOWLEDGMENT & UNDERSTANDING OF WFMA PRIVACY PRACTICES.

**PATIENTS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_**

**PREVIOUS NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I UNDERSTAND THAT THE PATIENT’S HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT DEVEN MEDICAL CENTER WORKS VERY HARD TO PROTECT THE PATIENT’S PRIVACY AND PRESERVE THE CONFIDENTIALITY OF THE PATIENT’S PERSONAL HEALTH INFORMATION. I UNDERSTAND THAT DEVEN MEDICAL CENTER MAY USE AND DISCLOSE THE PATIENT’S PERSONAL HEALTH INFORMATION TO HELP PROVIDE HEALTH CARE TO THE PATIENT, TO HANDLE BILLING AND PAYMENT AND TO TAKE CARE OF OTHER HEALTH CARE OPERATIONS. (IN GENERAL, THERE WILL BE NO OTHER USES AND DISCLOSURES OF THIS INFORMATION UNLESS I PERMIT IT. I UNDERSTAND THAT SOMETIMES THE LAW MAY REQUIRE THE RELEASE OF THIS INFORMATION WITHOUT MY PERMISSION. THESE SITUATIONS ARE UNUSUAL. ONE EXAMPLE WOULD BE IF A PATIENT THREATENED TO HURT SOMEONE.)

WFMA HAS A DETAILED DOCUMENT CALLED THE “NOTICE OF PRIVACY PRACTICES.” IT CONTAINS MORE INFORMATION ABOUT THE POLICIES AND PRACTICES PROTECTING THE PATIENTS PRIVACY AND IS ATTACHED TO THIS ACKNOWLEDGMENT. I UNDERSTAND THAT I HAVE THE RIGHT TO READ THIS “NOTICE” BEFORE SIGNING THIS ACKNOWLEDGMENT.

DEVEN MEDICAL CENTER MAY UPDATE THIS ACKNOWLEDGEMENT AND “NOTICE OF PRIVACY PRACTICES.” IF I ASK, I WILL BE PROVIDED WITH A COPY OF THE MOST CURRENT “NOTICE OF PRIVACY PRACTICES”.

WITHIN THIS “NOTICE” IS CONTAINED A COMPLETE DESCRIPTION OF MY PRIVACY/CONFIDENTIALITY RIGHTS. THE RIGHTS INCLUDE BUT ARE NOT LIMITED TO, ACCESS TO MY MEDICAL RECORDS, RESTRICTIONS ON CERTAIN USES RECEIVING AND ACCOUNTING DISCLOSURES AS REQUIRED BY LAW; AND REQUESTING COMMUNICATION IS BY SPECIFIED METHODS OF COMMUNICATIONS OR ALTERNATIVE LOCATION.

DEVEN MEDICAL CENTER HAS ESTABLISHED PROCEDURES WHICH HELP THEM MEET THEIR OBLIGATIONS TO PATIENTS. THESE PROCEDURES MAY INCLUDE OTHER SIGNATURE REQUIREMENTS, WRITTEN ACKNOWLEDGMENT,AUTHORIZATIONS, REASONABLE TIME FRAMES FOR REQUESTING INFORMATION, CHARGES FOR COPIES AND NON-ROUTINE INFORMATION NEEDS ECT. I WILL ASSIST DEVEN MEDICAL CENTER BY FOLLOWING THESE PROCEDURES IF I CHOOSE TO EXERCISE ANY OF MY RIGHTS DESCRIBED IN THE “NOTICE OF PRIVACTY PRACTICES.”

\***MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN GIVEN THE CHANCE TO REVIEW A CURRENT COPY OF DEVEN MEDICAL CENTER’S “NOTICE OF PRIVACY PRACTICES.”**

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**PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL SIGNATURE/RELATIONSHIP TO PATIENT**

**DATE AND TIME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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## CONSENT FOR TREATMENT & BILLING OF INSURANCE

I RECOGNIZE AND ACCEPT FULL RESPONSIBILITY FOR ALL SERVICES RENDERED AND AUTHORIZE RELEASE OF ANY INFORMATION NECESSARY TO PROCESS MY CLAIM AND ASSIGN REQUEST PAYMENT DIRECTLY TO THE PROVIDER.

**\*SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

## ATTENTION: MEDICARE PATIENTS ONLY

OUR CENTER HAS BEEN APPROVED AS A RURAL HEALTH CLINIC. MEDICARE CLAIMS ARE PROCESSED BY BCBS OF TENNESSEE. IN ORDER FOR US TO FILE WITH BCBS OF TENNESSEE, THEY REQUIRE A SIGNATURE FROM YOU SIGNIFYING THAT YOU ARE ALLOWING US TO FILE MEDICARE CLAIMS FOR YOU AND ARE REQUESTING PAYMENT TO US. YOUR SIGNATURE WILL ALLOW US TO RELEASE ANY MEDICAL INFORMATION THAT MEDICARE MAY NEED TO PROCESS YOUR CLAIM.

**PLEASE READ AND SIGN THE FOLLOWING TO PERMIT PAYMENT OF MEDICARE BENEFITS TO RURAL HEALTH CLINIC**

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS ON MY BEHALF OF ANY SERVICES FURNISHED MY BY DEVEN MEDICAL CENTER. I AUTHORIZE ANY HOLDER OF MEDICAL AND OTHER INFORMATION ABOUT ME TO BE RELEASED TO MEDICARE AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS RELATED SERVICES.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT SIGNATURE / MEDICARE NUMBER**

**DATE: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

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# MEDICATION POLICY AND PROCEDURES

1. PATIENTS MUST BRING **ALL** MEDICATION BOTTLES TO **EVERY** OFFICE VISIT.
	1. *EXCEPTIONS* INCLUDE: SICK VISITS, PAP SMEARS, EAR LAVAGES, SKIN PROCEDURES AND BLOOD DRAWS.
	2. HOSPITAL FOLLOW -UPs **MUST** BRING MEDICATION BOTTLES AND DISCHARGE PAPER WORK.
	3. IF MEDICATION BOTTLES ARE NOT PRESENT AT OFFICE VISIT REFILLS MAY NOT BE GIVEN AT THE TIME OF VISIT. ELECTRONIC MEDICATION LIST NEEDS TO BE UPDATED AT **EVERY** OFFICE VISIT.
	4. PHONE CALLS FOR MEDICATION REFILLS WILL BE **LIMITED TO EMERGENCY** REFILLS ONLY. IF AN EMERGENCY REFILL IS REQUIRED YOU **MUST** CONTACT THE OFFICE 24 HOURS IN ADVANCE. WE WILL **NOT** FILL REQUESTS FROM THE PHARMACY.
	5. FOLLOW UP APPOINTMENTS ARE REQUIRED TO BE KEPT TO GET REFILLS. i.e.: A 90 DAY SUPPLY OF MEDICATION IS SUFFICIENT FOR A 3 MONTH FOLLOW UP. PLEASE KEEP APPOINTMENTS WITHIN THE TIME FRAME OF YOUR MEDICATION REFILLS.
	6. CONTROLLED SUBSTANCES **MUST** BE RECEIVED AT THE TIME OF THE OFFICE VISIT AND WILL **NOT** BE CALLED IN IF YOU ARE NOT SEEN. *–REFER TO CONTROLLED CONTRACT*
	7. ANTIBIOTICS WILL **NOT** BE CALLED IN WITHOUT BEING SEEN FIRST; THEY WILL **ONLY** BE GIVEN AFTER SEEN BY THE PROVIDER.

IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE FEEL FREE TO ASK YOUR MEDICAL ASSISTANT OR PROVIDER. PLEASE OBTAIN COPY FOR YOUR RECORDS. THANK YOU.

 \***PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\***SIGN NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DATE**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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## AUTHORIZATION TO RELEASE HEALTH INFORMATION

**PATIENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SS#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE THE USE OR RELEASE OF THE ABOVE NAMED INDIVIDUAL’S HEALTH INFORMATION AS DESCRIDED BELOW:

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO RELEASE INFORMATION:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR RELEASED IS AS FOLLOWS:

EMERGENCY DEPT. \_\_\_\_\_\_ RADIOLOGY \_\_\_\_\_\_ LABS\_\_\_\_\_\_ CONSULTATION \_\_\_\_\_\_

PATHOLOGY\_\_\_\_\_\_ ENTIRE RECORD \_\_\_\_\_\_ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_**I UNDERSTAND THIS INFORMATION MAY INCLUDE RECORDS RELATED TO ***SEXUALLY TRANSMITTED DISEASE, AIDS/HIV, BEHAVIORAL OR MENTAL HEALTH SERVICES OR TREATMENT FOR ALCOHOL OR DRUG ABUSE.*** THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Deven Medical Center** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 11707 N WILLIAMS ST. STE 3** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DUNNELLON, FL 34432**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_**352-465-1919 OR 352-447-2122**\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_**352-465-7576**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND IT MUST BE IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE MEDICAL RECORDS DEPT. I UNDERSTAND THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL **EXPIRE ON THE FOLLOWING DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. IF I FAIL TO SPECIFY AN EXPIRATION DATE, THIS AUTHORIZATION WILL EXPIRE IN 60 DAYS.

I UNDERSTAND THAT AUTHORIZING THE RELEASE OF THIS HEALTH INFORMATION IS VOLUNTARY. I UNDERSTAND I CAN REFUSE TO SIGN THIS RELEASE. I NEED NOT SIGN THIS FORM IN ORDER TO ASSURE TREATMENT. I MAY INSPECT THIS FORM OR COPIED INFORMATION TO BE RELEASED AS PROVIDED IN 45 CFR 1642524. I UNDERSTAND ANY RELEASE OF INFORMATION CARRRIES WITH IT THE POTENTIAL FOR RE-RELEASE BY THE RECIPIENT, AND MAY NOT BE PROTECTED BY THE PRIVACY LAWS. IF I HAVE ANY QUESTIONS I MAY DIRECT THEM TO THE OFFICE MANAGER.

\***SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF WITNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE FAXED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAXED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEVEN MEDICAL CENTER**

WEST FLORIDA MEDICAL ASSOCIATES, PA

**Ulhas T. Deven, M.D.** 11707 N. Williams Street 41 N Inglis AveBOARD CERTIFIED INTERNAL MEDICINE Dunnellon, FL 34432 Inglis, FL 34449 **Elizabeth Pike, ARNP-C** Phone : (352) 465-1919 Phone: (352) 447-2122
BOARD CERTIFIED FAMILY NURSE PRACTITIONER Fax (352) 465-7576

**Samantha Kreisle, ARNP-C**

BOARD CERTIFIED FAMILY NURSE PRACTITIONER

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I AUTHORIZE THE USE OR RELEASE OF THE ABOVE NAMED INDIVIDUAL’S HEALTH INFORMATION AS DESCRIDED BELOW:

THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO RELEASE INFORMATION:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR RELEASED IS AS FOLLOWS:

EMERGENCY DEPT. \_\_\_\_\_\_ RADIOLOGY \_\_\_\_\_\_ LABS\_\_\_\_\_\_ CONSULTATION \_\_\_\_\_\_

PATHOLOGY\_\_\_\_\_\_ ENTIRE RECORD \_\_\_\_\_\_ OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_I UNDERSTAND THIS INFORMATION MAY INCLUDE RECORDS RELATED ***TO SEXUALLY TRANSMITTED DISEASE, AIDS/HIV, BEHAVIORAL OR MENTAL HEALTH SERVICES OR TREATMENT FOR ALCOHOL OR DRUG ABUSE.*** THIS INFORMATION MAY BE RELEASED TO AND USED BY THE FOLLOWING INDIVIDUAL OR ORGANIZATION:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\***DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF WITNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE FAXED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAXED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_