

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*



Vivid Pathology

Quest Diagnostics

Diagnostic Center

DERMATOLOGY & LASER CENTER

Rheumatology/ Ultrasound

Doctors Call Center

Courtyard Café

ORTHOPEDIC SURGERY

Gulf Region Postal Center

SleepDiagnostic CENTER

Release of Information

VCS

The Urology Center

Walgreens  
AT THE CORNER OF HAPPY & HEALTHY

WELCH SKIN CARE CENTER

DERMATOLOGY & LASER CENTER

WELCH SKIN CARE CENTER

Davita

STOP

STOP

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

Guest Services and Medical Center Clinic are proud to offer a COMPLIMENTARY shuttle service for our patients, visitors, and guests. The MCC shuttle can meet you your car and deliver you to the correct building.

The shuttle is in service every:

Monday - Friday  
7AM - 5PM

*\*In the event of lightning, the shuttle will begin service again 30 minutes after the last strike in the area.*

To **request a pickup from your car** please call 850.291.2646. Be sure to give a description of your vehicle and area of the parking lot.

To **catch the shuttle after your appointment**, please wait under the portico of either building or call 850.291.2646.





# 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.

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## 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 provide 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 adverse 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

# Medical Center Clinic

## Notice of Health Information Privacy Practices

Effective September 23, 2013

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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 programs, 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](mailto: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/](http://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:**

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



**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



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?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_) (5) \_\_\_\_\_  
 Knee Replacement -  Right  Left (Date: \_\_\_\_\_) (6) \_\_\_\_\_  
 Stents (Date: \_\_\_\_\_) (7) \_\_\_\_\_  
 Other: \_\_\_\_\_ (8) \_\_\_\_\_

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

	Yes	No		Yes	No
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Frequent UTIs	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
MRSA	<input type="checkbox"/>	<input type="checkbox"/> If yes, where? _____	VRE	<input type="checkbox"/>	<input type="checkbox"/> If yes, where? _____

**HEALTH MAINTENANCE:**

Lipid(cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colonoscopy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No Were any polyps removed? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Ever had an abnormal result?	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____
Pap Smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Ever had an abnormal result?	<input type="checkbox"/> Yes <input type="checkbox"/> No If so, when? _____
DEXA scan /Bone scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
PSA (prostate)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date: _____	Abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____	(5) _____	Reaction: _____
(2) _____	Reaction: _____	(6) _____	Reaction: _____
(3) _____	Reaction: _____	(7) _____	Reaction: _____
(4) _____	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

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

**FAMILY HISTORY:** Indicate which relative has had the following

<input type="checkbox"/> 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)										

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

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Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_

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Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_



**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:**

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: \_\_\_\_\_