Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 237
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com

Patient Demographic Information

PLEASE COMPLETE IN BLACK INK

Patient Name:	Date of Birth:

Today's Date: _____Age: _____ Sex:_____

Child's Legal Guardian(s):_____

Parent/Guardian's Name:_____

Parent/Guardian's Occupation:_____

Parent/Guardian's Cell Phone: (_____) _____ DateofBirth:_____

Parent/Guardian's Email Address: _____

Parent/Guardian's Name:_____

Parent/Guardian's Occupation:_____

Parent/Guardian's Cell Phone: (_____) _____ Date of Birth: _____

Parent/Guardian's Email Address: _____

Patient's Home Address:_____

City:_____ State: _____ Zip Code: _____

Home Phone: (_____) _____

Alternate Home Address:_____

City:_____ State: _____ Zip Code: _____

Child's Primary Care Physician:_____

Physician's Phone Number: (_____) _____

Physician's Fax Number: (_____) _____

Pharmacy Name: _____

Pharmacy Phone Number: (_____) _____

Pharmacy Fax Number: (_____) _____

Who has referred this child: _____

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Parent Questionnaire

*PLEASE COMPLETE IN **BLACK INK***

Patient Name:	Date of Birth:

Form Completed By: Mother ☐ Father ☐ Other: _____

Referring Physician: _____

Child Profile

What concerns do you have about your child: (please a brief summary of the main concerns)?
When were the problems first noticed? Have they progressed? How have they been handled so far?

What has your child been told about coming for this evaluation?

Past/Current Treatment History

Please list or describe any chronic medical problems (asthma, diabetes, developmental delays, etc).
Please describe any major illnesses, surgeries, or hospitalizations.

Is your child currently taking any medications (including supplements/vitamins)? No ☐ Yes ☐ If yes, specify:

Does your child have any allergies? No ☐ Yes ☐ If yes, specify:

Are your child's immunizations up to date? Yes ☐ No ☐ If no, please explain:

Has your child had vision and hearing screening performed either by your physician at the school? If yes, please specify when, by whom and results:

Has your child had previous neurological, developmental/behavioral, psychological, or psychiatric evaluations and/or treatment (e.g., medication, counseling, tutoring, speech, physical or occupational therapy, not described above and by whom?

Patient Name:	Date of Birth:

Birth History

Was your child born two or more weeks before the "due date"? No☐ Yes ☐

If yes, how many weeks early was your child born? _____ weeks early

How much did your child weigh at Birth _____

Biological Father's age at birth of your child _____ Biological Mother's age at birth of your child _____

Number of pregnancies prior to this child _____ Number of miscarriages prior to this child _____

Were there any problems during the pregnancy, labor/delivery or following the birth? No ☐ Yes ☐

If yes, please specify:

Was your child born by C-Section? No ☐ Yes ☐

If yes, please specify why:

Were any substances or medication used by the mother during the pregnancy? No☐ Yes☐

If yes, please specify (e.g., prescription medication, alcohol, tobacco, etc.)'

Developmental History:

(Please *write in* age. Ages in *parenthesis* are *approximate normal limits.)*

***Check this box and skip the following history if all milestones were on time*:** ☐

Gross Motor:	***Fine Motor:***
Rolled over (4-5 mos) _____ Sat without support (6-7 mos) _____ Walked alone (12-16 months) _____ Runs (15-18 mos) _____ Catches a ball (3 years) _____ Hops on one foot 2-3 times (4 years) _____	Copies circle (3 years) _____ Copies Square (5 years) _____ Adaptive /Self help: Drinks from a cup (12 – 15 mos) _____ Uses a spoon (15-24 mos) _____ Undresses completely (3 years) _____ Dresses Completely (4 years) _____
Language Development:	***Social/Emotional Development***
Babbles (6 mos) _____ Understands "NO" (9-10 mos) _____ 3-5 word vocabulary (12 mos) _____ Follows 1 step command with gestures (12 mos) _____ Can point to several body parts (16-17 mos) _____ 2-word phrases (24 mos) _____ Follows 2 step command (24 mos) _____ 3 word sentences (3 years) _____	Temperament as a baby (e.g. easy, colicy): Shy with strangers (7-8 mos) _____ Plays cooperatively with peers (4 yrs) _____ Current temperament/mood (e.g. irritable, anxious, happy):

Are there any current problems or concerns with development not mentioned already?

Patient Name:	Date of Birth:

Patient **Review of Systems**

Has your child had any problems mentioned below that you haven't already described?

	Y	N	Explain
Weight loss or gain			
Weakness			
Rash			
Itching			
Light or dark skin color changes			
Changes in hair growth or loss			
Headaches			
Double vision			
Neck stiffness or pain			
Chest pain			
Palpitations			
Fainting/passing out			
Heart murmurs			
Shortness of breath			
Wheezing			
Appetite changes			
Indigestion/reflux			
Nausea, vomiting or diarrhea			
Recent changes in bowel habits			
Change in urinary frequency			
Bed wetting			
Problems with menstruation			
Joint pain, swelling or redness			
Convulsions			
Staring spells			
Tremor			
Incoordination (ataxia, tremor)			
Anxiety / Depression			
Anemia			
Bleeding Tendency			
Previous Blood Transfusions			
Lymph node enlargement or tenderness			

Patient Name:	Date of Birth:

Family **Medical History (*other* than patient)**

Please include all pertinent ***FAMILY history*** for first and second-generation ***FAMILY members***.

	Y	N	***Family*** **Member's relationship to child**
Trouble learning to read			
Trouble with arithmetic			
Trouble with writing			
Attention Deficit/Hyperactivity disorder			
Other school problems			
Speech problems			
Language delay			
Behavior problem in childhood			
History of physical or emotional abuse			
Depression			
Anxiety/Phobia/panic disorders			
Other Mental illness			
Drinking problems			
Drug Abuse			
Seizures			
Mental Retardation			
Autism			
Headaches/Migraines			
Tourette Syndrome			
Neurologic Conditions			
Congenital Anomalies			
Diabetes			
High blood pressure			
Irregular Heartbeat or rhythm			
Heart attack before 40 years old			
Thyroid condition			
Deafness			
Blindness			
Any other disorders in the family			

Patient Name:	Date of Birth:

Social history

Child's School: _____ City: _____

Teacher's Name: _____ Grade: _____

Type of Classroom: Regular ☐ RSP ☐ Special Day Class 0

IEP/504:_____

This child is currently living with:

☐ Biological mother and biological father

☐ Biological mother

☐ Biological father

☐ Adoptive parents. Is your child aware that he/she is adopted? _____

☐ Foster parents

☐ Other (specify) _____

The biological parents of this child are currently:

☐ Married to each other (Years married: ___)

☐ Divorced from each other

☐ Separated from each other

☐ Never married to each other

Please list all people who are currently living in this child's household (name, age, and relationship to child):

Name	Age	Relationship

Other Concerns

Are you concerned about issues not covered in this questionnaire? Please describe:

Thank you for completing this questionnaire. It will be reviewed as a valuable first step in evaluating your child.

Patient Name: _____

Date of Birth: _____

M-CHAT-R™

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Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?) Yes ☐ No ☐
2. Have you ever wondered if your child might be deaf? Yes ☐ No ☐
3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) Yes ☐ No ☐
4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs) Yes ☐ No ☐
5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?) Yes ☐ No ☐
6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach) Yes ☐ No ☐
7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road) Yes ☐ No ☐
8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?) Yes ☐ No ☐
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck) Yes ☐ No ☐
10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) Yes ☐ No ☐
11. When you smile at your child, does he or she smile back at you? Yes ☐ No ☐
12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?) Yes ☐ No ☐
13. Does your child walk? Yes ☐ No ☐
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? Yes ☐ No ☐
15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do) Yes ☐ No ☐
16. If you turn your head to look at something, does your child look around to see what you are looking at? Yes ☐ No ☐
17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say “look” or “watch me”?) Yes ☐ No ☐
18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don’t point, can your child understand “put the book on the chair” or “bring me the blanket”?) Yes ☐ No ☐
19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) Yes ☐ No ☐
20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee) Yes ☐ No ☐

D3 **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

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NICHQ

National Initiative for Children's Healthcare Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0350

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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11-19/rev1102

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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11-20/rev0303

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Patient Name:	Date of Birth:

Financial Agreement 2024

I understand that Dr. Przeklasa Auth is an "in-network provider" for Monarch HealthCare HMO, Mission Hospital Allied Physicians HMO, Cigna PPO, Anthem Blue Cross PPO, Blue Shield of California PPO, and United PPO. For all other insurance plans I understand that Dr. Przeklasa Auth is an "out-of-network provider" and I am financially responsible for all charges incurred for services rendered. Your insurance company requires us to collect co-payments, coinsurance, and/or deductible amounts at the time of service. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Once we receive your insurance Explanation of Benefits, if there is any outstanding balance we will notify you of the amount and automatically charge the below credit card within 48 hours. Any "no shows" or cancellations with less than 24 hours notice will incur a fee equivalent to the scheduled appointment $500 for a new patient appointment and $200 for a follow-up appointment. If your insurance changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Person Financially Responsible:

Name:_____

Cell Phone: (_____) _____

Email Address: _____

Home Address:_____

City:_____ State:_____ Zip Code: _____

Credit Card Authorization Visa and Mastercard ***ONLY***. We do not take American Express.

Card Type (Circle): ☐ VISA or ☐ MASTERCARD

Name on Card: _____

Card Number: _____

Home Address: _____

Verification Code: _____

Expiration Date: _____

_____

Signature

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Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com

Patient Name:	Date of Birth:

Authorization to Consent to Treatment of a Minor

I, the undersigned parent to:_____ , a minor, do hereby authorize Melissa Przeklasa Auth, M.D., as agent for the undersigned to consent to any examination, medical diagnosis or treatment which is deemed advisable and to be rendered at the office.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian

Special Letters, Forms, and Prescriptions

I understand that if I request a letter written or a form completed, describing any medical conditions and/or treatments, I will be charged a fee of $25 for this service. Any medication changes or prescriptions requested in between visits, I will be subject to a $25 charge. Controlled substance prescriptions will only be sent electronically.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian

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Medication Policy

Effective December 1, 2022

Dr. Przeklasa will provide you with enough medication until your next follow-up appointment. Your child will need to be seen in the office for follow-up visits until he or she is stable on the medication. Frequent follow-ups are necessary in the beginning stages to assess for any side effects and to assist with adjusting the medication to find the proper dosage. Once your child is stable on medication, office visits will typically be spaced out to every 4-6 months.

With regard to stimulant medications, they are strictly controlled by the DEA. The original prescription must be sent electronically under controlled procedures in order to be filled. These medications are only written for a 30-day supply without refills.

Any medication refills, changes, or lost prescriptions requested, in between visits, will be subject to a $25 charge.

If your insurance requires a prior authorization for medication, it can take up to seven business days. All prior authorizations are performed on Mondays and Thursdays. Please be sure that your pharmacy sends us the required documentation, we cannot proceed with a prior authorization without the appropriate pharmacy codes.

Thank you for your cooperation.

Patient Name: _____

Parent Name: _____

Date: _____

Parent Signature: _____

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Patient Name:	Date of Birth:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Melissa Przeklasa Auth, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Melissa Przeklasa Auth, M.D. describes such uses and disclosures more completely.)

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available in the reception area, and that a copy of any amended Notice of Privacy Practices is also available on this medical practice's website.

Melissa Przeklasa Auth, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Office Manager; 30131 Town Center Drive # 237; Laguna Niguel, CA 92677; (949) 495 - 6100.

With this consent, Melissa Przeklasa Auth, M.D. may call, mail or email my home or other alternative location (including leaving a message on voice mail) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Melissa Przeklasa Auth, M.D. may use my PHI for continuity and coordination of my treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Our office may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

I have the right to request that Melissa Przeklasa Auth, M.D. restrict how she uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Melissa Przeklasa Auth, M.D. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Melissa Przeklasa Auth, M.D. may decline to provide treatment to me.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian Date

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

I hereby authorize: _____
DOCTOR/HOSPITAL

_____
ADDRESS

_____
PHONE NUMBER/FAX NUMBER

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE FROM/TO:

MELISSA PRZEKLASA AUTH, M.D.

30131 Town Center Drive Suite # 237, Laguna Niguel, CA 92677
Office: (949) 495-6100 Fax: (949) 354-0612

The medical information/records will be used for the following purpose: _____
This authorization is:
[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis & Treatment)
[ ] Limited to the following medical information:_____

I also consent to the specific release of the following records:
Genetic Information _____(initial)
Drug/Alcohol/Substance Abuse_____(initial)
HIV Diagnosis/Treatment _____(initial)
Tests for Antibodies to HIV _____(initial)
Psychiatric/Mental Health _____(initial)

DURATION:
This authorization shall be effective immediately and remain in effect until: _____

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.
A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.
PATIENT'S NAME: _____DATE OF BIRTH: _____
ADDRESS: _____
PHONE NUMBER: _____

Signature of patient *or legal/personal representative*: _____
Relationship *if other than patient:* _____

DATE: _____