Patient Name_____ Male Female Age_____

Date of birth_____ Social Security #_____ Phone_____

Email (required for electronic med records access)_____

Address_____

City_____ State_____ Zip_____

Pharmacy_____ Address or Street _____

City_____ Phone_____ Fax_____

Chief complaints_____

Height_____ Weight_____ Blood pressure_____ Pulse_____

Drug Allergy: _____ Severe? Moderate? Mild? Very mild?
anaphylaxis bloating/gas bradycardia chest pain conjunctivitis cough diarrhea difficult speak/swallow dizzy/lightheadedness facial swelling hives irregular heartbeat itchiness loss of consciousness nausea pain/cramping patchy swelling rash-general rash-local respiratory distress runny nose shortness of breath tachycardia tongue swelling vomiting wheezing

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Additional drug allergies: _____

non-smoker ex-smoker 1-9/day 10-19/day 20-39/day 40+/day cigar pipe chew

non-alcohol user past alcohol excess 1-3 drinks/day 4-6 drinks/day more than 6 drinks/day

Do you have a medical marijuana card? _____ Do you intend to get one? _____

PLEASE PROVIDE A PRECISE LIST OF ALL PRESCRIPTIONS, MILLIGRAMS PER PILL AND NUMBER OF PILLS TAKEN PER DAY OR WEEK OR MONTH

Brain, spine, nerve, heart, cancer surgery?_____ When? _____

Brain, spine, nerve, heart, cancer surgery?_____ When? _____

Can you become pregnant? _____ If no, why not? _____

Emergency contact_____ Phone_____

Referring physician or source_____ Phone_____

Fax_____ NPI#_____ Medicaid #_____

Signature_____ Date _____

Authorization to Use and/or Disclose Medical Records

I authorize the above to use and/or disclose a copy of the specific health and medical information identified below for (Name of Patient) _____ to **The Malka Institute of Neuroscience and Disease** for the following purposes:

☐ Continued Medical Care ☐ Personal Information ☐ Legal Follow-Up

☐ Disability ☐ Insurance

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____ Please send the entire medical record (all information) to the above-named recipient.

_____	All therapist/technician records	_____	Clinician office chart notes
_____	Office notes and reports	_____	X-ray films
_____	Transcribed hospital reports	_____	Laboratory reports
_____	Medical records for continuity of care	_____	Most-recent five-year history
_____	Emergency records	_____	Rx
_____	Billing statements		
_____	Diagnostic imaging/X-ray reports	_____	Other _____

*The following items must be initialed to be included in the use and/or disclosure of other health information:

_____ *HIV/AIDS-related information and/or records/communicable diseases

_____ *Mental health information and/or records

_____ *Genetic testing information and/or records

_____ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed).

Describe: _____

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use/or disclose the information may not receive compensation for doing

so.

I further understand the I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taking in reliance upon this authorization. Unless revoked earlier, this authorization will expire from **180 days** from the date of signing or until (date) _____.

Print Patient's Name Date

Signature of Patient or Patient's Legal Representative Date

Print Name of Legal Representative (if applicable) Relationship to Patient

Notice Of Privacy Practices for Protected Health Information HIPPA

This notice describes how medical information about you may be disclosed and how you may get access to this information. Please review it carefully!

We safeguard information about your health and person: We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance, and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of the computer's operations.

Typical uses and disclosures of medical information: We collect medical information from you. Within our office, we restrict the disclosure of this information to doctors, nurses, technicians, and insurance and billing personnel. We may use your information for treatment and care, payment to insurers, and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities, and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extensive care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure including, but not limited to:

When required by law

Public health activities (death, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recall, disease/infection exposure, disease/injury/disability control/prevention

Health oversight activities (audits, investigations, inspections)

Judicial and administrative proceedings (court orders)

Appropriate law enforcement request (to identify or locate a suspect, fugitive, material witness, or missing person)

Deceased person information to coroners, medical examiners, and funeral directors

Organ and tissue donation

Research provided authorization is IRB-approved or privacy board approved

Emergencies or to avert serious threat to health or safety

Specialized government functions (military, inmates)

Worker's compensation

Disaster relief

We will not use or disclose your medical information for any purpose not listed without your specific written consent. Any specific written consent you provide may be revoked at any time by writing to us.

Patient Privacy Rights

You have the right to: Inspect and copy medical information from your chart, you may submit a written request to our office and pay a copy fee and receive a copy of your records. We must respond within thirty 30) days if the record is readily available and within sixty (60) days if it is not readily available.

Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within sixty (60) days.

Receive an accounting of any disclosures made from your record over the last six years starting April 14, 2010. You can get this with a written request directed to our office. We must respond within 60 days.

Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supersede the typical disclosures noted above. You may revoke or restrict consent.

Request confidential communications. All communications in our office are confidential. You may specifically-request that all communications be confidential with a written request directed to our office.

Receive a copy of this notice by printing it or with a written request directed to this office and a copy of this notice will be given with all new patient packets.

We may contact you for Appointment Reminders, and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the privacy Notice and an opportunity to receive and understand.

Our Responsibilities under HIPAA:

We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.

We reserve the right to make changes to this notice. We will post a notice that the notice has been changed and the effective date of the change, copies will be available.

You can make a complaint about our privacy policy or its execution either verbally or in writing to our Privacy Officer at: 7539 Medical Dr., Hudson, FL 34667

If you fail to receive a resolution to your complaint, you can send a written statement to this office to the Secretary of Health and Human Services.

I have received and understand this practice's notice of privacy which provides in detail the uses and disclosures of my protected health information that may be made by this practice, individual rights, and how I may exercise my rights.

Signature Date