West-Ky Abrams, D.O., P.A.

Board Certified Family Practice and Functional and Regenerative Medicine, A4M Advanced Fellow

Memorial Hospital Miramar
Medical Office Building, Suite 308
1951 S.W. 172nd Ave.
Miramar, FL 33029
www.miramardoctor.com ***Office: 954-431-1904*** ***Fax: 954-431-1914***

Welcome To Our Office! We look forward to ***"Taking Care of You from the Inside & Out."***

Dr. West-Ky Abrams and Staff takes your health and wellness very seriously and focuses on prevention and teaching. We offer exceptional healthcare and are committed to providing you with thorough and personalized care. We take care of your family members from ages 10 years and up.

Dr. Abrams is Board Certified in Family Practice and Functional & Regenerative Medicine and offers effective and proven Weight Loss Programs, Allergy Testing & Personalized Medicine for Optimal Health.

Please arrive 20 minutes prior to your appointment time.

Please bring **all** of the following with you to our office: Thank you!!!

Complete patient registration forms (download from **www.miramardoctor.com**)
Current insurance card Driver's license
Copay/Deductible (if applicable) Labs, imaging reports & medical records
Current medications & all supplements you are taking
All minors must have written authorization or accompanied by legal guardian

Abrams Medical Center Office Information

Office Hours: (subject to change)
Mon – Fri 8 – 4 (All Patients)
Saturday 9 – 12 (weight loss patients)

FOLLOW-UP APPOINTMENTS: Dr. Abrams and Staff at Abrams Medical Center take your care and treatment very seriously. We encourage you to schedule appointments for preventive health visits, annual exams, physicals, pap smears, wellness exams and for chronic medical conditions. Our Providers may order various tests, therapies, medications or counseling and our staff will schedule a follow-up appointment. We expect you to follow the treatment plan and keep your scheduled follow-up appointment. Please take your health seriously or take it someplace else.

PRESCRIPTION REFILLS: Please call your pharmacy first to determine if you have refills left. If you do not have a refill left, your pharmacist will send us an electronic refill request. We will refill your prescription directly to the pharmacy within 24-72 hours. If your prescription is not refilled, please call our office as to the reason why. Please notify us of any changes in your pharmacy selection. New regulations require you to pick up your prescription in our office for non-narcotic controlled substances. These prescriptions cannot be faxed.

CHANGES: Please notify our office of changes to your address, telephone, cellular phone, new health conditions with you or in your family and family/marital status.

AUTHORIZATIONS: We require a minimum of 5 – 10 business days to fulfill an authorization request.

SHOES: The Florida Department of Health requires you to keep your shoes ON when being weighed.

GENERIC MEDICATIONS: For your convenience, this office dispenses Generic Medications.

PATIENT INFORMATION

FIRST NAME:_____ MI:_____ LAST NAME:_____DATE:_____

DATE OF BIRTH:_____ SOC SEC #:_____ ☐ FEMALE ☐ MALE

ADDRESS:_____CITY:_____ STATE:____ ZIP CODE:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ OTHER

CELL PHONE:_____HOME PHONE:_____ WORK PHONE:_____

EMPLOYER:_____ OCCUPATION:_____

Emergency Contact:_____ Number:_____Relation:_____

Our office utilizes email and automated phone calls for appointment reminders and other information.

Please provide a private email address so you can receive important information from our office.

May we contact you by email and phone? Circle One: Yes No

Email: _____@_____ Main Telephone:_____

GUARANTOR & PARTY RESPONSIBLE FOR BILL

FIRST NAME:_____ MI:____ LAST NAME:_____ RELATIONSHIP:_____

DATE OF BIRTH:_____ SOC SEC #:_____ ☐ FEMALE ☐ MALE

ADDRESS:_____CITY:_____ STATE:____ ZIP CODE:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

PRIMARY INSURANCE:_____

POLICY:_____ GROUP NUM:_____

SUBSCRIBER NAME: _____

SOC SEC#:_____DOB:_____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE:_____

POLICY:_____ GROUP NUM:_____

SUBSCRIBER NAME:_____

SOC SEC#:_____ DOB:_____

RELATIONSHIP TO PATIENT: _____

ASSIGNMENT/RELEASE OF BENEFITS & CONSENT FOR TREATMENT

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance and assign directly to West-Ky Abrams, D.O., P.A., all insurance benefits, if any. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize West-Ky Abrams, D.O., P.A. to charge my credit card on file if there are any outstanding balances on my account. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also authorize West-Ky Abrams, D.O., my attending physician, to examine and treat me. I also authorize such treatment and procedures, as deemed necessary by the physician and staff, including but not limited to, the taking of such X-rays, medications, blood samples, urine samples and other therapies. I am aware that the practice of medicine is not an exact science and I acknowledge that NO guarantee or assurance has been or implied to me as to the results that may be obtained by examination and treatment.

_____ _____

Signature of Patient or Legal Guardian **Date**

Medical History – (Please be as complete as possible)

Name:_____ Age:_____ Date:_____

How did you hear about us? _____

Are you interested in our Weight Loss Program? Yes _____ Want to start today?_____

Reason for today's visit: _____

Last Annual/Full Exam with Blood Work: _____

(Important for insurance billing purposes)

Current Diagnosed Medical Problems:

_____

_____

Any **DRUG** Allergies NO / YES _____

Any Non-Drug Allergies (i.e. Latex, shrimp…)_____

Current Medications (list name, dose, frequency and bring to your office visit)

_____

_____

Past or Current Medical Conditions: (diabetes, high cholesterol, high blood pressure, thyroid, cancer: breast, colon, prostate, other)

_____

_____

List Any Surgeries & Date:

_____

_____

Family History: (i.e. diabetes, high cholesterol, high blood pressure, cancer)

_____

_____

Social History: (married, single, divorced…what do you do for a living…)

_____

Country of Birth: _____ Religion: _____

Do you Smoke: (Never, No) Yes & What: _____

Alcohol: (Never, No) Yes & What: _____

Nutritional Supplements: _____

Drug/Substance Abuse: _____

Do you have any addictions or addictive behaviors:_____

Domestic Violence: _____

Mental Health History: _____

Sexually Transmitted Diseases or other Diseases: _____

Other information you would like to tell Dr. Abrams: _____

1. How is your energy through the day? _____
2. How is your sleep quality? _____
3. How do you feel when you wake-up? _____
4. How is your libido/sex drive? _____
5. Do you have a good relationship with your partner? _____
6. Any problems with your periods? _____
7. Any PMS symptoms? _____

Women	***Men***
Last Period_____	Last Testicular Exam_____
Number of Pregnancies _____	Last Prostate Exam_____
Number of Children_____	Last Colonoscopy_____
Current Birth Control_____	Last Eye Exam_____
Last PAP _____	Last Stress Test_____
Last Mammogram _____	Last EKG_____
Last Breast Exam _____	Last CXR_____
Last Colonoscopy_____	Bone Density_____
Last Eye Exam_____	
Last Stress Test_____	
Last EKG _____	
Last CXR_____	
Bone Density _____	

Previous Primary Care Provider: _____

Telephone:_____

Name of Specialists: _____

_____

Patient Responsibilities

Welcome to our office!!!

If this is your first time here, you will notice that our office is very different from most family practice offices.
We have compassionate and exceptional staff who go out of their way to help you. Our providers and staff do listen!!!
Dr. West-Ky Abrams, Layda Labiste, ARNP and Diana Cherkiss, PA-C, go beyond the "standard of care" and focus on treating the causes of your problems rather than just your symptoms. Our goal is to provide you with options to avert disease, strive for your optimal health to improve your vitality and longevity.
You will recognize that we make your healthcare needs our top priority!

The new Health Care Law called the **Affordable Care Act (ACA)** is enforcing requirements for your health that pertain to us as providers and to you as patients. These include required exams, follow-up appointments for chronic diseases and numerous parameters and guidelines that everyone must meet (including children).
This healthcare collaboration and attention requires you to have some responsibilities:

Comply with Treatment Plans: The Affordable Care Act (ACA) requires us to achieve specific parameters and requirements regarding your health. These often require more frequent monitoring and follow-up appointments. Once you and our providers agree upon the goals of therapy and a treatment plan, you have a responsibility to cooperate with that treatment plan and to keep your agreed-upon appointments. **Compliance with this new law is mandatory.** Your physician's treatment instruction is often essential to public and individual safety. You also have a responsibility to disclose whether agreed upon treatments are being followed, or not, and to indicate when you would like to reconsider the treatment plan. If your compliance becomes an issue whereby we cannot effectively treat you, we will consider discharging you from our practice.

Be Honest With Providers: You have a responsibility to provide an honest, complete medical history including information about past illnesses, medications, hospitalizations, family history of illness, and to notify us of any changes to your personal information. Good communication is essential to a successful patient-physician relationship so being truthful and express your concerns clearly to our providers.

Be Respectful to Our Staff and Providers: Our staff is exceptional and work very hard to help you with everything!!! Just as it's your right to expect respect from us, it is your responsibility to show us respect in return. This is not to suggest that you need to be so respectful that you are afraid to ask questions or request clarification on issues regarding your health. Rather, it is recognizing that commanding respect means giving it in return -- on both sides of the patient/provider equation. We will discharge you immediately for verbal and/or physical abuse, foul language, threats and/or fraudulent activity or behavior.

Educate Yourself: Please participate in your medical education and request information or clarification about your health status or medical treatments or prescriptions when you do not fully understand what has been described. Do your research and ask questions. An educated patient is our best patient!

Maintain Healthy Habits: You should be committed to your own health maintenance through health enhancing behavior. Disease can often be prevented by simply adjusting your lifestyle. Our providers will discuss with you what healthy adjustments can be made. Therefore, you need to take personal responsibility when you are able to avert the development of disease. Please take your health seriously or take it someplace else.

Avoid Putting Others at Risk: You should also have an active interest in the effects of your conduct on others and refrain from behavior that unreasonably places the health of others at risk. Please inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.

Meet Your Financial Obligations: You have a responsibility to meet your financial obligations for your medical care. Understanding your insurance contract, its benefits and limitations, its financial portion, copays, deductibles, and co-insurance is your responsibility. It is a contract between you, your employer and your insurance company. We are very happy to help you with this and we also have very reasonable fees for self-paying patients. However, when appointments are missed and you did not respect us and provide 24 hours notice, we will charge you a $60.00 no show fee for that missed appointment. Other patients wanted that time slot and we do not overbook. After 2 no show appointments, you are subject to discharge from the practice.

Make Responsible Decisions: Please discuss organ donation as well as end-of-life decisions with our physicians. It is important that you make your wishes known. Such a discussion might also include writing an advance directive or will.

I, _____ have read, understand and agree to all of the terms and conditions of my Patient Responsibilities and understand that this agreement will be in full force and effect upon my signature.

Signature: _____ Date: _____

Abrams Medical Center

Financial Policy

Effective: January 1, 2016

Thank you for choosing Abrams Medical Center as your health care provider. We are committed to "taking care of you from the inside & out" by providing you with the most thorough, timely and caring treatment. We expect you to comply with our financial policy so we can concentrate on providing you and your family with the highest quality healthcare and maintain lower prices for our self-paying patients and for our services by reducing our billing costs.

INSURANCE:
As a courtesy to you, our staff will file a claim to your health insurance carrier. All co-pays, coinsurance and deductibles are due at your visit. We will be happy to provide a receipt of your payment. We cannot bill your insurance company unless you provide our office with your correct insurance information. It is your responsibility to notify our office of ANY changes to you, your family or to your insurance coverage. You must also provide information to your insurance company when they request it from you. Failure to do so may result in an insurance denial for the claim and you will be responsible for the payment. Your insurance policy is a contract between you, your employer and your insurance company. We are NOT a party to that contract. You agree to pay any portion of the charges not covered by insurance. Prior to your visit, please make sure you have notified your insurance carrier that Dr. West-Ky Abrams is your primary health care provider.

CO-PAYS:
Co-Pays are due at the time of visit. Please provide your insurance card with your copayment. It is unlawful to waive copayments, deductibles and/or co-insurance.

PAYMENT:
Our staff will do the best they can to charge you an estimated amount if you have coinsurance and unmet deductibles based on your insurance policy. If we overcharge you, we will save your credit for your next visit as soon as we receive payment from the insurance carrier or we will reimburse you.

FORMS:
There is a $30 fee for any forms to be filled out. Insurance does not cover this or the time it takes to fill out. Forms will not be accepted unless you fill out your sections first.

MONTHLY INVOICES:
Our office will give you a courtesy call if you have a balance on your account. We can process this balance by phone with MasterCard, Visa or Discover. We also take cash and checks. We offer recurring credit card charges if needed. If you cannot take care of your balance by phone, you will receive a monthly invoice. It will show any previous balance, any new charges, late fees and any payments and credits applied during the month. We will gladly discuss any items on your invoice. The balance on your invoice is due immediately and if not paid within thirty (30) days, is subject to late fees. There is a fee of thirty dollars ($30) for any checks returned by the bank.

LATE FEES:
A late fee will be imposed on each item of your account that has not been paid within thirty (30) days from the time the item or service was added to the account. The late fee will be computed at the rate of two percent (2%) per month or an annual percentage rate (APR) of twenty-four percent (24%). The minimum finance charge is $2 per month.

CANCELLATIONS/NO SHOWS:
Our goal is to provide exceptional quality medical care in a timely manner. We also need to maintain The Affordable Care Act (ACA) requirements and guidelines. In order to do so, we've had to implement new policies to help each patient understand how important every visit is. As such, we require a minimum of 24 hours notice in order to cancel or reschedule your appointment. Please call our office: 954-431-1904 if you cannot keep your scheduled appointment. If you do not reach a live receptionist, please leave a detailed message with your name, phone number and date of your appointment. We will call you back! The message will count as notification. If you fail to notify our office with at least 24 hours notice and you do not show up, you will be charged a **$60 NO SHOW FEE**. After 2 "no show" appointments, you are subject to discharge from our practice.

I, _____ have read, understand and agree to all of the terms and conditions of this Financial Policy and understand that this agreement will be in full force and effect upon my signature.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *January 01, 2007* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, *Kelly M. Abrams, R.N., B.S.N.* Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, email, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ *1.00* for each page and the staff time charged will be $ *25.00* per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: West-Ky Abrams, D.O., P.A.

Privacy Officer: Kelly M. Abrams, R.N., B.S.N.

Telephone: 954-431-1904 Address: 1951 S.W. 172nd Ave., Fax: 954-431-1914

Suite 308, Miramar, FL 33029

LIVING WILL

(This form should be used when the patient has the capacity to make decisions)

Declaration made this _____day of _____, 200____.

I, _____, willfully and voluntary make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I hereby declare:

If at anytime I should have a terminal condition and if my attending physician has determined that there can be no recovery from such condition and that my death is imminent, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or alleviate pain.

I, _____ (indicate do or do not) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedure would serve only to prolong artificially the process of dying.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures please indicate the desired alternative below:

Please check A or B

( ) **A.** It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences of such refusal.

OR

( ) **B.** I designate_____ to make treatment decisions on my behalf should I be diagnosed as suffering from a terminal condition and comatose, or otherwise mentally or physically incapable of communication.

If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have NO force or effect during the course of my pregnancy.

LIVING WILL

Furthermore, if I should be diagnosed by my attending physician and two (2) consulting physicians, who have medical specialties relevant to my condition, as being in a permanent vegetative condition or irreversibly comatose, it is my express desire and intention that life-prolonging procedures be withheld and/or withdrawn from me when the application of such procedures would serve only to prolong artificially the process of dying and that I be permitted to die naturally with only the administration of medication or performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I understand the full impact of this declaration and I am emotionally and mentally competent to make this declaration.

_____ _____

Signature **Date**

This declarant is known to me and I believe him or her to be of sound mind.

Witness _____Date_____

Witness_____Date_____

NOTE: One witness should be either a spouse or blood relative to the patient.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

West-Ky Abrams, D.O., P.A.
1951 S.W. 172nd Avenue
Suite 308
Miramar, Florida 33029

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____
Employee signature *Date*

West- Ky Abrams, D.O., P.A.
Board Certified Family Medicine

1951 S. W. 172nd Avenue, Suite 308
Miramar, Florida 33029
Office (954) 431-1904

Please Fax Records to 954-431-1914

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO:_____

Office Phone: _____ Office Fax: _____

I hereby authorize release of my complete medical history to Abrams Medical Center. These records are to include psychiatric, substance abuse and HIV testing/AIDS related complex information.

Please complete all sections below:

_____ _____
PATIENT SIGNATURE DATE

_____
PATIENT'S NAME (PRINTED)

_____ _____
DOB SOCIAL SECURITY

_____ _____
WITNESS DATE

ABRAMS MEDICAL CENTER

1951 SW 172nd Avenue, Suite #308
Miramar, FL 33029
Phone: 954-431-1904 Fax: 954-431-1914

PERMISSION TO RELEASE INFORMATION

I GIVE PERMISSION TO WEST-KY ABRAMS, D.O., P.A. TO RELEASE MEDICAL AND/OR BILLING INFORMATION PERTAINING TO ME, TO THE FOLLOWING INDIVIDUALS:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____ _____

DATE PATIENT SIGNATURE WITNESS