FOOTHILL PULMONARY & CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

Patient Personal Information

Name:______________________________

Address:______________________________

City/State/Zip:______________________________

Social Security Number:________________________

Date of Birth:____/____/____

Circle Gender: Female Male

Phone (Home): (_____)____________________

Phone (Work): (_____)____________________

Phone (Cell): (_____)____________________

Primary Language:________________________

Need Interpreter: (Check One) Yes____ No____

Occupation/Student: ________________________

Employer/School:________________________

Referred By:______________________________

Responsible Party Information

Name:______________________________

Address:______________________________

City/State/Zip:______________________________

Social Security Number:________________________

Date of Birth:____/____/____

Phone (Circle Home/Work/Cell): (_____)__________

Relationship to Patient:________________________

Emergency Contact

Name:______________________________

Phone (Home/Work/Cell): (_____)________________

Relationship to Patient:________________________

Insurance Information

Insurance Carrier:______________________________

Insurance I.D. #:______________________________

Type (Circle One) HMO PPO POS Medicare Medi-Cal

Secondary Insurance:________________________

Subscriber's Name:________________________

Subscriber's Date of Birth:____________________

Spouse Information

Name:______________________________

Address:______________________________

City/State/Zip:______________________________

Date of Birth:____/____/____

Phone (Circle Home/Work/Cell): (_____)__________

Relationship to Patient:________________________

Pharmacy:______________________________

Authorization

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up lab information, prescriptions, other referral information from Foothill Pulmonary and Critical Care Consultants Medical Group, Inc., and to make and receive phone calls regarding my health and/or the billing related to the service provided to me by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc.

☐ SPOUSE:______________________________

☐ CAREGIVER:______________________________

☐ CHILDREN:______________________________

☐ OTHER:______________________________

ASSIGNMENT OF BENEFITS

I hereby assign payment of authorized Medicare and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either for me or on my behalf to Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. "I certify that I am eligible for benefits under the pre-paid health benefit plan. In the event I am later found to be ineligible, or as consideration for being treated without proof of eligibility, I agree to pay for any and all services provided by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. at their fees then in effect."

SIGNATURE:____ DATE:____________________

HIPAA PRIVACY POLICY

Our notice of Privacy Practices advises how we may use and disclose protected health information about you. Our current notice is available in our lobby, or upon request. I agree to the uses and disclosures of my information for purposes of treatment, payment, and practice operations.

SIGNATURE:____ DATE:____________________

FOOTHILL PULMONARY & CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.
959 E. Walnut St., Suite 120 | Pasadena, CA 91106 | 626.795.5118 301 W. Huntington Dr., Suite 607 | Arcadia, CA 91007 | 626.445.4558
1818 Verdugo Blvd., Suite 207 | Glendale, CA 91208 | 818.790.1730 101 E. Beverly Blvd., Suite 307 | Montebello, CA 90640 | 323.888.2548

DEAR SLEEP PATIENTS,

The results of your sleep study will be given to you by appointment only. Please call the office to schedule a follow up appointment as soon as your study is scheduled. Results are not given over the phone. The office will not call you to go over your results.

YOU MUST SEE THE PHYSICIANS TO GET YOUR RESULTS

Thank you for your cooperation.

PACIENTES DE ESTUDIO DE SUEÑO.

Los resultados de su estudio de sueño son dados por cita solamente. Llame por favor a la oficina para una cita, después de su estudio. Los resultados no son entregados por teléfono y nuestra oficina no le llamara.

ES MANDATARIO VER AL DOCTOR PARA CONSEGUIR SUS RESULTADOS

Gracias por su cooperación.

____

Patients Signature (Pacientes Signatura) Date (Fecha)

FOOTHILL PULMONARY & CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

____

Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian | Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:______________________ Last four digits of his/her SSN (required):__________

Print Name:______________________ Last four digits of his/her SSN (required):__________

Print Name:______________________ Last four digits of his/her SSN (required):__________

____

Name of Patient (Print) | Signature | Date

Witness: ______________________ Date: ______________

◊ 959 E Walnut St., STE 120 | Pasadena, CA 911016 | 626.795.5118
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Foothill Pulmonary and Critical Care Consultants Medical Group INC.

NextGen Patient Portal Authorization

Patient Name: ______________________________________

Email (Print): ______________________________________

IN EVENT OF AN EMERGENCY, DIAL 911.
Do Not Use the Patient Portal for Urgent or Emergent Matters.

Purpose of this Form
Our Medical Office offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works
A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate
You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal by going to https://nextmd.com/

Protecting Your Private Health Information and Risks
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

Conditions of Participating in the Patient Portal
Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold Foothill Pulmonary and Critical Care Consultants Medical Group INC. or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password. **If you have questions we will gladly provide more information.** *Policies & Procedures are subject to change without notice.*

(Optional) Please allow access to my Patient Portal information to:

______________________________ ______________________________
Print Name Relationship

Patient/Patent/Guardian Acknowledgement

______________________________ ______________
Patient Signature Date

Foothill Pulmonary & Critical Care Consultants Medical Group, INC.

EPWORTH SLEEPINESS QUESTIONNAIRE

Patient's Name:	DOB:

How likely are you to fall asleep during the day in the following situations, in contrast to just feeling tired/fatigued?

0 = Would Never	1 = Slight Chance	2 = Moderate Chance	3 = High Chance

Situation	Chance of Dozing			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. movie theater)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest during the day when circumstances permit	0	1	2	3
While in a car that is stopped	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3

Breathing

Breathing		
Do you snore?	☐ Yes	☐ No
Do you stop breathing during sleep?	☐ Yes	☐ No

Restless Legs

Restless Legs		
Do your legs bother you at night?	☐ Yes	☐ No
Do your legs twitch at night?	☐ Yes	☐ No
If yes, does movement give relief?	☐ Yes	☐ No

ADULT PATIENT QUESTIONNAIRE

Name: ______________________________ **Date of Birth:** ____________

Name of physician/provider you are seeing today: ______________________________

Medications:
Are you currently taking any medications? ☐ No ☐ Yes
please list medication and dosage if known:

____

____

____

Allergies:
Are you allergic to anything? ☐ No ☐ Yes, please list drug(s) and reaction(s):

____

____

Immunizations (approximate dates are fine):

Date of your last flu shot? ____________ ☐ None

Date of your last pneumonia shot? ____________ ☐ None

Date of your last tetanus shot? ____________ ☐ None

Date of your last Hepatitis A shot? ____________ ☐ None

Date of your last Hepatitis B shot? ____________ ☐ None

Family History (possible genetic illnesses):
Has anyone in your immediate family had any illnesses, such as, heart disease, cancer, diabetes, etc ☐ No ☐ Yes, please list which family member and illness?

____

____

Social History:

Occupation: ____________ Employer: ____________ ☐ Retired

Are there any occupational hazards at your place of employment such as: asbestos, chemical, excessive noise, potentially toxic fumes? ☐ No ☐ Yes, Please list:

____

Do you smoke? ☐ No ☐ Yes, please list quantity: ____________

Do you drink alcohol? ☐ No ☐ Yes, please list quantity: ____________

Do you drink caffeine? ☐ No ☐ Yes, please list quantity: ____________

Do you use any illicit drugs? ☐ No ☐ Yes, please list quantity: ____________

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Dear Patient,

In order to serve you, our valued patient, in a more efficient manner, please be advised of the following office policies:

1. **Pulmonary Consultation Requirements:**

As pulmonary specialists, it is very important that, along with the enclosed history forms, you also bring along all pertinent information. We ask that you bring to your appointment any chest x-ray films and Cat Scans of the chest that have been done within the last 5 years. Please have all relevant x-rays and Cat Scans put on CD-Rom if possible.

Films may be obtained at the radiology group where the x-rays or Cat Scans were originally performed. **PLEASE DO NOT RELY ON FILMS BEING DELIVERED TO OUR OFFICE**. To ensure a complete consultation, please pick up the films and hand-carry them in at the time of your appointment. Please have all relevant x-rays and Cat Scans put on CD-Rom if possible.
If you have any questions or difficulty obtaining your films, please give us a call prior to your appointment so that we may assist you.

2. **Medication Refills:**

Please have your pharmacy contact our office 3 to 5 days prior to when your medications are expired or completed. Practice good healthy habits and call us with your medication requirements prior to completion of your prescription. This policy allows you to take your medication without any interruptions or compromise in your health and well-being. Routine medication refills (*including all CPAP and BiPAP equipment*) require at least one yearly follow up exam with your physician.

PRESCRIPTION REFILLS ARE NOT PROCESSED ON SATURDAY OR SUNDAY OR AFTER HOURS. Please allow 48 hours for all refills to be processed. Patients *must* be seen within one year for any refills. We are not responsible for your prescription plan coverage. Please read your medical plans pharmacy policies.

3. **Laboratory/Diagnostic testing:**

All test results are reviewed by the ordering physician within 1 working day of receiving the results. Patients will only be notified of abnormal test results requiring treatment. Patients are always encouraged to contact our office during normal business hours (Monday through Friday 9 a.m. to 5 p.m.) to obtain verbal results from our nurse.

4. **Cancelled/Missed Appointments:**

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than a 24 hour notice you will be charged a $25.00 fee. Foothill Pulmonary reserves the right to bill the patient according to the scheduled fee or according to the rules of the patient's health plan. You will be billed unless another appointment is made.

5. **Authorization/Eligibility:**

Because of the contractual relationship between Foothill Pulmonary and all managed care insurance plans, I am aware that every visit requires pre-authorization prior to any procedures or lab tests, which may delay health care. Co-payments are expected to be paid at the time of service and are required for each visit.
AUTHORIZATION FORMS MUST BE PRESENTED AT THE TIME OF SERVICE OR YOU MAY BE REFUSED SERVICE OR BE RESPONSIBLE FOR THE BILL AT THE TIME OF SERVICE. I understand I must be seen prior to the expiration date of the authorization, and must be eligible with the insurance at the time of service. I will notify the office of any change in my insurance, primary care physician, or demographic information. Failure to do so may delay the billing process and/or medical care.

6. **Disability forms and other non-insurance forms:**

Due to the complexity of completing certain disability forms and other non-insurance forms, effective August 21, 2008 office has instituted a charge of $35.00 per form to complete these forms. This includes but is not limited to SDI, FMLA, DMV, Electric or Gas Company, jury duty, and airline forms. If you have any questions about this fee, please speak with one of the office staff.

7. **Consent to treat**

The examination you will be receiving is a focused one, for the express purpose of pulmonary or sleep related diagnosis and treatment.

The doctor-patient relationship established by this examination/treatment is limited to this specific purpose. We perform only the examination and care necessary to address this current problem.

Because of this narrowly limited purpose, it is important that we advise you that this examination does not replace your regular medical evaluations done by your personal physician. If you have any other questions of concerns about your health, you must discuss these with your own doctor.

Please be advised, if 3 years have passed since your last visit you will be considered a new patient.

We provide this information because we would like you to be able to plan for your entire health care needs and not inappropriately rely on a limited purpose visit as if it were a comprehensive examination of your overall health. Your ongoing partnership and working relationship with our office and staff allows us to better meet your medical needs. We appreciate, very much, your cooperation and adherence to our policies. We understand the need for personalized medical care and we strive to meet your needs.

Do you have any personal, religious, or cultural preferences which may affect or influence the way you want to be treated?

Yes_________ No_________

If you answered yes, please explain

____

____

I agree to allow the physicians of Foothill Pulmonary to render medical care to:

____
Patient's Name

I have read and understand the above information and agree to all of the terms stated above.
My signature below represents my acceptance of these policies.

______________________________ ____________________
Patient's signature Date

CAIR California Immunization Registry

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry.*

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, tell your doctor or download a "*Decline or Start Sharing/Information Request Form*" from the CAIR website (http://cairweb.org/cair-forms/) and FAX or email it to the CAIR Help Desk at **1-888-436-8320** or CAIRHelpDesk@cdph.ca.gov.

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

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* *By law, public health officials can also look at the registry in the case of a public health emergency.*

California Department of Public Health: Med Office IZ Registry Disclosure Letter rev 7/13 **IMM-891 E/S**

SLEEP DISORDERS QUESTIONNAIRE

I. CHIEF COMPLAINT

A. What is bothering you or your bed partner concerning your sleep or lack of sleep?

____

____

II. YOUR EXPECTATIONS

A. What would you like to see changed or improved?

____

____

1. Your desired bedtime? _________
2. Your desired wake up time? __________

III. YOUR "NORMAL" SLEEP PATTERN

A. Weekdays

1. Usual bedtime __________
   a. I go to bed as late as ___________ (number of days per week _____)
   b. I go to bed as early as ___________ (number of days per week _____)
2. Usual wake up time __________
   a. I arise as late as ___________ (number of days per week _____)
   b. I arise as early as ____________(number of days per week _____)

B. Weekends and Days Off

a. Usual bedtime ranges from ____________ to ____________
b. Usual wake up time ranges from ____________ to ____________

C. Sleep Initiation

1. On average, how long does it take for you to fall asleep? ____________

D. Sleep Maintenance

1. On average, how many times do you awaken during the night? ______
   a. What causes you to awaken? ____
   b. What time do you usually awaken during the night? __________
   c. After you awaken, how long does it take you to fall back to sleep? ___________

E. Sleep Quantity

1. How many hours do you sleep at night?
   a. Weekdays______
   b. Weekends/Days off ______

PATIENT NAME: ____ **DATE:** ________________________

F. Naps

1. Do you nap during the weekdays? ______
   a. If yes,
      How many naps per week? ______

      How many naps per day? ______

   b. If yes, how many hours per day do you nap? ______

2. Do you nap on weekends or days off? ______
   a. If yes,
      How many naps per day? ______

      How many hours per day? ______

G. Shift Work

1. Do you currently engage in shift work? ______
   a. If yes, state your work hours ____________________
2. Have you ever engaged in shift work in the past? ______
   b. If yes, how long ago? ____________________

IV. DAYTIME ALERTNESS OR SLEEPINESS

A. Circle the one number that best describes your level of alertness or sleepiness right now.

1. Feeling active, vital, alert, and wide awake.
2. Functioning at a high level, but not at peak, able to concentrate.
3. Relaxed, awake, but not fully alert, responsive.
4. A little foggy, let down.
5. Foggy, beginning to lose track, difficulty staying awake.
6. Sleepy, prefer to lie down, woozy.
7. Cannot stay awake, sleep onset appears imminent.

B. Do you fall asleep during	often	sometimes	rarely	never
Driving	_____	_____	_____	_____
Reading	_____	_____	_____	_____
Watching TV	_____	_____	_____	_____
Meetings	_____	_____	_____	_____
Conversations	_____	_____	_____	_____
Meals	_____	_____	_____	_____

C. Have you ever been involved in an automobile accident? ______

1. If yes, due to falling asleep? ______

D. Have you ever had an accident at work? ______

1. Describe

____

____

V. NOCTURNAL BEHAVIORS, MOVEMENTS, AND SENSATIONS (confer with bed partner)

A. Snoring
   1. Do you snore? ______
      a. If yes, how loud? ______________________________
      b. If yes, in what position (e.g. back vs. side)? ______________________________
      c. If yes, is snoring continuous, or fragmented (circle)?
      d. How long have you snored? ______________________________
      e. Has your snoring gotten worse? ______________________________

B. Breathing
   1. Do you ever appear to stop breathing while asleep? ____________

C. Movements
   1. Do you kick your legs while asleep? ____________
      a. If yes, (circle)

         Often

         Occasionally

         Rarely

   2. Do you have sensations in your legs which bother you? ____________
      a. Describe

         ____

   3. Do you grind your teeth or chew while asleep? ____________
      a. If yes, (circle)

         Often

         Occasionally

         Rarely

   4. Do you talk while asleep?
      a. If yes, (circle)

         Often

         Occasionally

         Rarely

   5. Do you sleep walk?
      a. If yes, (circle)

         Often

         Occasionally

         Rarely

   6. Other behaviors during sleep which concern your bed partner?

      ____

      ____

VI. BEDTIME ACTIVITIES

A. Do you eat in bed? ___________

B. Do you read in bed? ___________

C. Do you watch TV in bed? ___________

D. Do you worry in bed? ___________

1. If yes, does it interfere with your sleep? ___________

E. Other activities in bed ___________

VII. MISCELLANEOUS

A. Have you ever felt paralyzed, unable to move, while lying in bed? ___________

1. If yes, (circle)

Often

Occasionally

Rarely

B. Do you ever have unusually vivid dreams or hallucinations when about to fall asleep or just after awakening? ___________

1. If yes, (circle)

Often

Occasionally

Rarely

2. Describe ___________

____

C. Have you ever had a sudden complete, partial or subtle loss of muscle strength? ___________

1. If yes, (circle)

Often

Occasionally

Rarely

2. Describe ___________

____

VIII. MEDICATIONS, DRUGS, ALCOHOL

A. Caffeinated Beverages

1. How many cups of coffee per day? ______

2. How many cups of tea per day? ______

3. How many sodas per day? ______

B. Alcohol

1. How many drinks do you have per day/week? ___________

What do you drink? ___________

X. WEIGHT

A. Current Weight ___________

B. Heaviest Weight ___________

C. Lightest Weight ___________

D. Have you gained weight in the last five years? ___________

1. If yes, how much? ___________

XI. PSYCHIATRIC HISTORY

A. Have you ever been treated for a psychiatric illness? __________

1. Describe

____

____

B. Do you feel depressed? ___________

1. If yes, (circle)

a. Mild

b. Moderate

c. Severe

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Authorization to Release Protected Health Information

HIPPA Compliant Request for Information

Name of Patient ____________ Street Address ____________

Phone Number ____________ Fax Number ____________ City ____________ State ____________ Zip Code ____________

Email Address (please be sure to print clearly) ____________ Date of Birth (00/00/0000) ____________ Last Four Digits of SSN ____________

I hereby give the following person(s) or entity to release my protected Health Information (PHI):

Please choose the method of delivery by checking the preferred option and filling in the information where required. Be certain that information is accurate and complete. **Incomplete authorizations are invalid.**

_____ U.S. Mail to my personal address.
(Records will be mailed to address listed above)

_____ I prefer to pick up my records personally.
Please call me when they are ready.
(Photo ID will be required for pick up)

____ Please send my records to the following

Name of medical office/Company/Entity you want to receive the records.

Street Address

City State Zip Code

(__)__________________(__)__________________
Phone Number Fax Number

The protected Health Information (PHI) I would like to have released is as follows:

___ Release an abstract of my PHI (two (2) year summary)

___ Release my entire chart (subject to state regulated per page fees)
(You will receive an invoice. Records are not released until invoice is paid in full)

___ I would like specific dates of service ________________________________

Please provide the purpose of your request ________________________________

This authorization shall expire ninety (90) days from the date of signature, or at the following event: ______________

I am requesting my PHI to be disclosed for the following reason: ________________________________

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the health care provider at which this authorization was executed. Such revocation will be effect upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request.
The recipient of this protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law. Where permitted, the information I am requesting to be disclosed may sometimes be redisclosed by the recipient and may no longer be protected by law. I understand that this authorization will expire in 90 days from the date of my signature. I hereby acknowledge that I have read and fully understand the above statements that apply to me.

________________________________ ______________
Signature of Patient Date

________________________________ ______________
Signature of Parent/Guardian or Personal Representative (attach proper document) Date