Pediatric Patient Registration

Patient Name: ____________________________________ DOB ___________________ SS#________________________

Gender: M F Race: _____________________ Ethnicity: Hispanic Non-Hispanic Other: _________________

Email: ____

Legal Parent or Guardian if a minor: ____

Street Address: ____________________________________ City: _________________________ Zip: ___________________

Mailing Address: __________________________________ City: _________________________ Zip: ___________________

Home Phone #: _____________________ Cell #: ____________________ Work #: ______________________

Write first and last names of children and spouse if they are patients at this clinic: ________________________________

____

How did you hear about our office? ____ Friend _____ Newspaper _____ Internet _______ Other

Preferred Pharmacy: ____

Account Information

Responsible Party: ____ Relationship to Patient: ________________________

Driver's License# ____ SS#_____________________ DOB: ________________

Home Phone: __________________________ Work #: ______________________ Employer: _________________________

Insurance Company Name: ____ Phone: ________________________________

Member ID# ____ Group# ____

Policy Holder Name: _________________________________ DOB: ____________________ SS#:_____________________

Medicaid #: ____________________________________ Medicare #: ____

Secondary insurance information: ____

Emergency Contact: (must have different contact number other than patient's phone number)

Name: ______________________________ Relationship to patient: _________________ Phone #: ____________________

Address: _____________________________ City: _________________________ State: __________ Zip:_______________

Authority to Treat (please initial the appropriate statements)

______ I hereby authorize Heart 2 Heart Family Practice to treat, perform and/or order such diagnostic, laboratory, medical, surgical and x-ray procedures as are necessary in the provider's judgement for my care or the care of my child.

______ I am legally responsible for the above-named patient now and in the future when the child is brought in for care.

______ I permit a copy of this authorization to be used in place of an original and such document will remain in effect until revoked by me in writing.

Patient/Parent Signature: ____ Date: _________________________

No-Show Policy

Quality care for our patients is our priority. Please take a few minutes to review our no-show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No-Show" Appointment

Heart 2 Heart defines a "No-show" appointment as any scheduled appointment in which the patient either

- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 15 minutes late and is consequently unable to be seen.

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-show" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient.
- Is unfair (and frustrating) to other patients that would have taken the appointment.
- Disrespects not only the provider's time, but also the time of the entire staff.

How to Avoid Getting a "No-Show"

- Confirm your appointment.
- Arrive 5-10 minutes early.
- Give 24 hours' notice to cancel appointment.

1. Appointment Confirmation

Our automated health record will send an email 1 week prior to your appt. It will also send a text message 3 days prior to your appointment.

- ❖ Heart 2 Heart staff will also contact you three days and one day prior to your scheduled appointment to confirm your visit.
- ❖ If we are unable to speak with you, we will leave a message. To cancel an appointment, you will need to contact Heart 2 Heart by 2:30pm the business day before the appointment — otherwise the appointment will be considered a "no-show".

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our practice 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions and or to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or rebook a scheduled visit, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call.

Consequences of "No-Show" Appointments

If you miss 2 or more appointments within a year you will be charged a $25 No Show/Cancellation fee. Because it is difficult to fill an appointment cancelled without 24-hour notice and missed appointments will be charged a fee of $25

If you miss 3 or more appointments within a year you will lose your privilege to schedule future appointments and will only be able to schedule for a same day appt upon availability or you may be dismissed from the clinic.

1. Patient dismissal is at the discretion of your medical provider.
2. If you are not dismissed and need an appt., you will have to call in and be seen as the schedule allows for a sick visit. You will not be able to reserve an appt. Only emergency medical treatment will be offered within the first 30 days of dismissal.

I have read and understood the Heart 2 Heart Family Practice "No Show" Policy as described above.

____ _________________________________

Patient Signature Date

Permission to bring pediatric form

Date: ____________________

This is to verify that I will allow the following person(s) to bring my child to his/her appointments. In my absence this person(s) will be allowed to make necessary medical decisions for my child pertaining to that appointment.

____

____

____

____

Patient Name: ____

Parent/Guardian: ____Signature

____ Printed Name

Each person on the above list will need to show proper identification at the window.

If the names listed above need to be removed for legal reasons such as divorce of separation, it is the responsibility of the parent/guardian to contact this office immediately to notify us of the change. It will also be necessary for a new form to be completed at the next office visit to reflect the change.

Pediatric Health History Form

Patient Label

Name: ________________________________

Date of Birth: ________________________

Age: ________________________________

Your relationship to child: ________________________

Child's previous doctor/primary care provider:
____

Present health concerns: __________________________

____

Medicines/Vitamins: ____________________________
Herbs/ Home remedies: __________________________
Allergies/Reactions to medicines or vaccinations: ______
____

Pregnancy & Birth
Where was your child born? ______________________

Is the child yours by: Birth Adoption Stepchild
Other: _________________________

Please indicate any medical problems during pregnancy
None Specify: ________________________________
____

Delivery by Vaginal birth Caesarean
If caesarean, why? ______________________________
Birth Weight: _______________ Birth Length: ________
APGAR score 1min. ____________ 5 min.
____

Please indicate any medical problems during the baby's newborn period None (if premature, how early?)
____
Other problems: ________________________________

Nutrition & Feeding

Was your child breastfed? NO Yes
If so, how long? ________________________________
Has your child had any unusual feeding/dietary problem?
No Yes if yes, specify: _____________________
____

Milk intake now: Cow's Milk
(Nonfat 1% fat 2% fat whole
Soymilk Rice Milk
Average ounces per day (Note: 8 ounces = 1 cup)
____

Sleep
Hours per night ________________________________
Naps (number & length) __________________________
Any sleep problems? ____________________________

Development
At what age did your child: sit alone
Walk alone ______________Say words ____________
Toilet train(daytime)____________________________
Girls only: Age at first menstrual period____________

Dental history
Has child been seen by a dentist? □No □Yes
If so, how often? ______________________________
Date of visit____________________________________

Immunizations/infectious diseases
Please bring your child's immunization records to your appointment.
Has your child had any of the following diseases:
□Chickenpox □Measles □Mumps
□Rubella □Meningitis □Tuberculosis (TB)

Exposure/Habits
Any concerns about lead exposure? ______________
(Old home/plumbing/peeling paint) □No □Yes
Do any household members smoke? □No □Yes
TV – hours per day ____________________________
Computers - hours per ay________________________
Video games – hours per day______________________

Past Medical History
Please describe any major medical problems and their dates? ______________________________________
____
____

Hospitalization/Operations (with dates): ______________
____

Broken bones or severe sprains: ____________________
____

Family History
Please indicate any deaths of your immediate family members: ____
____
Please indicate family members (parents, sibling, grandparent, aunt or uncle) with any of the following:

Alcoholism ____
High Cholesterol __________________________________
Cancer, specify type ________________________________
High blood pressure ________________________________
Heart attack _______________________________________
Stroke ____
Depression/suicide__________________________________
Bleeding or clotting disorder_________________________
Genetic disorders___________________________________
Asthma/COPD _____________________________________
Diabetes____
Other____

Social history

Who lives at home?

Name	Age	relationship	high education level

Are your child's parents Married Unmarried Separated divorced
If divorced or separated, when? ____________________
Mother's Occupation_________________________________
Mother's Employer__________________________________
Father's Occupation_________________________________
Father's Employer___________________________________
Child care situation □parents □others (specify who and how often) ______________________________________
Concerns about your child: □alcohol □use Tobacco □Sexual activity □Aggressive behavior

Is violence at home a concern? No Yes

Are there guns in the home? No Yes

School History

Did/does your child attend school or preschool? □No □Yes
Current grade____________________

Name of school_________________________________
Any concerns about school performance?
____
Any concerns about relationships with:

Teacher's □No □Yes

Peers □No □Yes

If more than 4 years old: does your child have a best friend? □No □Yes

Sports/exercise: Type___________________________
How often? ____________________________________
How long (Minutes)? ___________________________
Review of symptoms: please check any current problems your child has on the list below:

General
___ *Fevers chills/excessive sweating*
___ *Unexplained weight loss/gain*

Eyes
___ *Squinting/" crossed" eyes/ Asymmetric gaze*

Ears/Nose/Throat
___ *Unusually loud voice/hard of hearing*
___ *Mouth breathing/snoring*
___ *Bad breath*
___ *Frequent runny nose*
___ *Problems with teeth/gums*

Cardiovascular
___ *Tires easily with exertion*
___*Shortness of breath*
___ *Fainting*

Respiratory
___ *Cough/wheeze*
___ *Chest Pain*

Gastrointestinal
___ *Nausea/vomiting/diarrhea*
___ *Constipation*
___ *Blood in bowel movement*

Genitourinary
__ *Bedwetting*
__ *Pain with urination*
__ *Discharge: penis or vagina*

Musculoskeletal
__ *Muscle/joint pain*

Skin
__*Rashes*
__*Unusual moles*

Allergy
__ *Hay fever/itchy eyes*

Neurological
__ *Headaches*
__ *Weakness*
__ *Clumsiness*

Psychiatric/Emotional
__ *Speech problems*
__ *Anxiety/stress*
__ *Sleep issues*
__ *Depression*
__ *Nail biting/ thumb sucking*
__ *Bad temper/breath holding/ jealousy*

Blood/Lymph
__ *Unexplained lumps*
__ *Easy bruising/bleeding*

Pediatric Consent

Health & development surveillance

After the birth of your baby it will be very important to bring the baby to the provider for regular healthcare checkups which assess growth and development as well as breastfeeding issues, prenatal education and immunizations. Heart 2 Heart Family Practice, PA clinical staff can continue to provide you with these services for your child. We welcome those who are seeking these services for their children who did not receive maternity care here at our facility. Regular care addressing issues like colds or ear infections is an important part of a relationship with your healthcare provider. If you are seeing a provider elsewhere for well child visits, it is important for you to see that provider for other health issues as well. They will be able to provide you with the best care as it relates to your child. If you would like to bring your child here for all issues relating to your child's health, we welcome you and hope to prove a warm and healthy environment for your child's healthcare needs.

Our Philosophy

Heart 2 Heart Family Practice, PA wants to work closely with families to provide continuous surveillance of infants and children to make sure growth, development, family bonding, and breastfeeding occurs normally and that parents have a ready source of guidance and information when they need it for successful parenting. We believe children who see the same healthcare provider at well visits establish a trusting relationship with their provider and become more comfortable when being seen for a sick visit. When your child does have an acute episodic illness, they are familiar with the surroundings and the providers therefore allowing for easier assessment of the problem.

Our Services

Our nurse practitioners and certified nurse midwives can provide both health maintenance and management of acute illness care to your infant/child at a reduced fee schedule. The well visits occur at regular intervals that provide for intervention in a timely way should a problem develop that the parent may be aware of. Immunizations are available and schedules for the administration of those shots will be discussed with each family. Physical exams, blood pressure, hemoglobin, lead level testing and other appropriate diagnostic testing can be done in the office. A referral is available if the patient needs a specific consult.

Transfer to physician care

In the course of caring for your child a problem may arise that needs further evaluation by a physician. A referral will be made to the appropriate provider. If it is determined that your child's healthcare should be followed by a physician a Transfer of Care can be made to the appropriate Physician's Office. All records will be sent to that office so there will be no interruption of care. Urgent health needs at night and on weekends can be directed to the closest ER or Urgent Care Facility. You may speak with one of our providers by calling the office number which is 386-659-2104 and following the prompts. A provider will return your call as soon as possible.

Your Responsibilities

You must agree to bring your child for scheduled well visits as outlined below. You must agree to take your child to referral appointments that are scheduled for them. If you are breastfeeding and having any issues, before stopping suddenly please call the provider during office hours for guidance if needed. An appointment may be needed for breastfeeding, education for guidance. Openly discuss your child's behaviors and family interaction with the new baby with the provider. Report any abusive behavior by any member of your household with the provider or other healthcare workers anywhere, anytime. Discuss immunizations with the provider and if you decline to have immunizations, please sign the declined recommended healthcare consent form. The nurses in the office can give you this form.

Well Child Visit Schedule

3 Days after Birth

2 Weeks

4 Weeks

6 Weeks

2 Months

4 Months

6 Months

9 Months

12 Months

15 Months

18 Months

2 Year and Yearly Thereafter

I understand the service and philosophy of Heart 2 Heart Family Practice, PA. I understand the contents of this consent regarding the services offered to my child. I understand that I may continue to bring my child to the Clinic and by doing so I consent to the services outlined in this form. I further understand that a physician is not at the clinic, but lines of communication are established for consulting with the overseeing pediatric physician as needed. I understand if the need arises, I may opt to transfer my child's care to a physician's office and the appropriate records will be sent. I understand in the event of an emergency to call 911 or to go to the nearest ER or Urgent Care Center and the follow up care here at Heart 2 Heart Family Practice, PA as the hospital advises.

__________________________________ ______________________

Signature of Parent/Guardian Date

Pledge of Patient Responsibility

Thank you for choosing Heart 2 Heart Family Practice, PA as your healthcare provider. We are committed to fulfilling our responsibilities in your successful treatment. However, for our relationship to be successful, it is important that you understand your responsibilities as a patient. They are as follows:

Patient Responsibilities

1. You need to keep your appointment, however if for some reason you cannot, it is your responsibility to give a minimum of forty-eight (48) hours' notice. Repeated failure to give appropriate notice could result in your provider discharging you from care.
2. It is your responsibility to pay patient co-pays, deductible and other appropriate fees at the service. Failure to pay in a prompt fashion could result in charging interest. If charged interest it is your responsibility to pay it promptly.
3. It is your responsibility to follow the treatment plan established by your provider. This means going to appointments for tests, consults, attending recommended therapies and doing home activities that have been recommended for you.
4. Prescription medicine may be a part of your treatment. It is your responsibility to follow instructions closely. No early refills in narcotics will be provided. Prescriptions can only be refilled during work days, Monday through Friday 9AM to 4PM.

I pledge to fulfill my responsibilities as a patient.

Signature: ____ Date:____________________

General Consent part 1

Heart 2 Heart Family Practice, PA is intended as an alternative approach to Childbearing, Primary care, well women and well man and well child care, in a small rural area where few services are available. It may appeal to and be desired by some people and not others. For this reason, we feel that you must be fully informed of our scope of services and limitations to more traditional physician services.

As our patient we require that you participate in orientation procedures generally performed on your first visit which includes but are not limited to 1. Your personal inspection of the facility. 2. Services, methods and procedures related to your healthcare. 3. Mutual expectations. 4. A discussion about recommendations and alternatives available to you or your child with regards to health decisions and lifestyle choices that affect your health. 5. Potential risks to the patients, childbearing couple and child that pertain to your personal history and circumstance and procedure for management of complications.

We have taken every reasonable precaution to ensure the safety, comfort and satisfaction of our essentially healthy client population that we service in this practice. We are not however a hospital and do not have extensive lifesaving equipment or highly specialized services that are needed in some crisis or emergencies that arise when people seek medical care. Basic lifesaving equipment and techniques will be used, and we will transfer all emergencies via 911 Ambulance to the nearest hospital.

Should consultation, referral or hospitalization become necessary during your care we will inform you in a timely manner of your options and make all of your records available to the referring physician and/or hospital. After your specialized care needs are met, you may return to us for continued healthcare management as long as you desire to do so and as long as your medical condition is stable.

It is the philosophy of this practice that whatever possible decisions about your health care are needed they will be made as a result of consultation with you the patient or patient's guardian. Do not hesitate at any time to ask questions you have about the practice and its services or functions as well as anything that concerns you, your child or your family. Continued enrollment in the practice is determined by your desire to work together with the clinical staff toward optimal health and your appropriateness as our patient. If the provider feels your care is more appropriate with another practice you will be informed, and the staff will help you to find care with a practice more appropriate for your healthcare needs.

I have read and agree with the above statements and have had the opportunity to ask questions.

____________________________________ ______________________

Patient/Guardian Signature Date

Financial Policies & Lifetime Authorization

1. **Release of Information** I, the below named patient or guardian do hereby authorize any provider examining and/or treating me to release any third party, such as an insurance company or governmental agency, medical records generated at Heart 2 Heart Family Practice, PA related to diagnosis and treatment when such information is requested by such third party for its use in determining a claim for payment for such treatment and or diagnosis.

2. **Physician Insurance Assignment**: I, the below named patient or guardian hereby authorize payment directly to any provider examining and/or treating me for medical and/or surgical benefits herein specified and otherwise payable to me for their service as described.

3. **Medicare/Medicaid:** I certify that the information given by me in applying for payment under Title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Administration/Division of Family Services or its intermediaries any information needed to determine a Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the provider treating me. I also understand that certain procedures or injections may not be covered by my policy and therefore I will be responsible for payment for these services.

4. I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the provider's office. This assignment will remain in effect until revoked by me in writing.

5. I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full at the time of service unless other arrangements are made in advance with the office.

6. I hereby assign all Medicaid and/or surgical benefits to include major medical benefits to which I am entitled (Medicare, Medicaid, Private Insurance or other health plans) to Heart 2 Heart Family Practice, PA for payment for services rendered to me by its providers.

7. I request that payments of authorized Medigap benefits be made on my behalf to Heart 2 Heart Family Practice, PA for services furnished to me. I authorize any holder of medical information about me to release any information needed to determine these benefits payables for related services.

You are responsible for any balances due for services rendered. We can only estimate insurance benefits and will file the insurance claims as a courtesy to our patients**. It is my responsibility to know my insurance yearly maximums, copays, and deductibles.** You are financially responsible for all charges not paid by your insurance company. You are financially responsible for any claims not paid by your insurance company within 90days.

Sliding fee Scale: Our office offers a sliding fee scale to those who qualify for a discount on services. Applications for this are available at the front office. Applications must be updated every six months.

Service Charge: A service charge of 1.5% per month will be charged unless prior arrangements have been made. Patient/Guardian understands that if this account is placed with a collection agency that he/she will be responsible for any collections and/or attorney's fees, plus costs.

Parent/Guardian Signature ____ Date ____________________________

Signature of Guarantor if different than above: ____

Notice of Privacy Polices

This notice describes how information about you may be used and disclosed and how you can get access to the information. Please review this document carefully.

Introduction

At Heart 2 Heart Family Practice, PA, we are committed to treating and using your protected health information responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective October 15, 2020 and applies to all protected health information as defined by federal regulation.

Understanding Your Health Record/Information

Each time you visit Heart 2 Heart Family Practice, PA, a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment and a plan for your future care or treatment. This information which is referred to as your health or medical record services as a:

- o Basis for planning your care and treatment
- o Means of communication among the many health professionals who contribute to your care
- o Legal Documents describing the care you have received
- o A means by which you or a third party payer can verify that services billed were provided
- o A tool in the education of health professionals
- o A source of data for medical research
- o A source of information for the public health officials charged with improving the health of this state and the nation
- o A source of data for our planning and marketing
- o A tool with which we can access and continually work to improve the care we render and the outcomes we achieve.

Notice of Patient Rights

Understanding what is in your records and how your health information is used helps you to ensure it accuracy, better understand who, what, when, where and why others may access your health information and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of this Medical Office, the information belongs to you. You have a right too:

- o Obtain a paper copy of this notice of information practices upon request
- o Inspect and copy your health record as provided for in 45 CFR 164.524
- o Amend your health records as provided in 45 CFR 164.528
- o Obtain an accounting of disclosures of health information as provided in 45 CFR 164.528
- o Request communications of your health information by alternative means to alternative locations
- o Request a restriction on certain uses and disclose health information except to the extent that action has already been taken

Our responsibilities

Heart 2 Heart Family Practice, PA are required to:

- o Maintain the privacy of your health information
- o Provided you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- o Abide by the terms of this notice
- o Notify you if we are unable to agree to a requested restriction
- o Accommodate reasonable request you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practice change, we will post a revised notice in our office and you may request a copy of the most current notice at any time.

We will not disclose your health information without your authorization except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information you may contact Heart 2 Heart Family Practice, PA Privacy Officer at 386-659-2104

If you believe your privacy rights have been violated you can file a complaint with our Privacy Officer or with the Office for Civil rights, US Department of Health and Human Services. There will be no retaliation for filling a complaint with either the Privacy Office of the Office for Civil Rights.

The address for the Office for Civil Rights is;

US Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. We will also provide your primary or referring physician or subsequent health provider with copies of various reports that should assist him or her in treating you. We will use your health information for payment from third party payer. We will use your health information for regular health operations.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangered one or more patients, workers or the public.

Patient Consent For use and Disclosure of Protected Health Information

I allow Heart 2 Heart Family Practice, PA to use and disclose my protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Heart 2 Heart Family Practice, PA have 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 our Privacy officer at 1326 SR 100, Melrose FL 32666.

Heart 2 Heart Family Practice, PA may call my home or other designed locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as but not limited to: appointment reminders, insurance items, clinical care, lab or clinical results etc.

Heart 2 Heart Family Practice, PA may mail to my home or other designated locations any items that assist the practice in carrying out TPO such as but limited to: appointment reminder cards and patient statements.

I have the right to request the restriction or disclosures of my Personal Health Information in an effort to carry out my treatment, payment and healthcare operations. However, I understand that the practice is not required to agree to my request but will comply with my request to the best of its ability.

I have received a copy of Heart 2 Heart Family Practice, PA Privacy Practice Notice for my records.

By signing this for, I am consenting to Heart 2 Heart Family Practice, PA use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Please restrict the use of my records as follows:____

____

Signature	Date
Patient's Name	Date of Birth
Legal Guardian	Date

1326 SR 100 Melrose, Florida 32666

Phone 386-659-2104 – Fax 386-659-2196

Authorization for use or disclosure of protected health information

Date:_________________________ Name: ____

DOB:________________________ Social Security # ____

Purpose of disclosure

Specific items requested:

____

Purpose of release: ______ Changing physician _____ Consult/2nd Opinion ____ Legal _____ School

______Insurance ____ Continuing Care _____ Other

1. I understand that this authorization will expire one (1) year or until after I revoke it in writing.

2. I understand that I may revoke this authorization at any time by notifying the Heart 2 Heart Family Practice, PA staff in writing and it will become effective the date the notification was received.

3. I understand the information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer be protected by Federal Privacy regulations

______________________________	________________	______________________________	_____________
Patient's Signature	Date	Parent/Guardian Signature	Date

Patient Declines to request any previous medical records.

______________________________	________________	______________________________	_____________
Patient's Signature	Date	Parent/Guardian Signature	Date

Previous Doctor or Practice Name: ____

Previous Doctor's Address: ____

Previous Doctor's Phone#:_______________________________________ Fax#______________________________