Florida Medical Clinic - Family Practice – Brandon & Riverview
Authorization for Release of Medical Information

2020 Town Center Blvd. Suite B Brandon, FL 33511
813-315-1500 / 813-377-1686 (fax)

7229 US HWY 301 South Riverview, FL 33578
813-677-8418 / 813-355-5906 (fax)

6037 Winthrop Commerce Ave. Suite 201 Riverview, FL 33578
813-315-1530 / 813-355-5909 (fax)

I, the undersigned, hereby authorize the release of any and all medical information and records, or as described below on:

Patient Name: _____

Birth Date: _____

Social Security Number: _____

Reason:

☐ Patient **Requesting** Medical Records from Other Practice.

☐ Chart Copies for Other Reasons (_____)

☐ Patient **Transferring** Out of Practice/FAXING RECORDS

{There will be a $15 Transfer Fee for ALL RECORDS (FAXED) or a charge of $1 per page, whichever is lowest}=This DOES NOT apply to patient's picking up medical record copies.

*****I request that Florida Medical Clinic release a copy of my medical records created by this office to the physician listed below. This authorization is valid thru _____/_____/_____(Month/Day/Year). I understand that I may revoke this consent in writing except to that the extent that the practice has already made disclosures in reliance upon my prior consent.*****

☐ **Send To:** ☐ ***Release From:****** ☐ *******Send To:*** ☐ **Release From:**

Florida Medical Clinic – Brandon/Riverview

_____ _____

_____ _____

_____ _____

This authorization is to ☐ ***include*** *or* ☐ ***exclude*** *psychiatric records, drug and alcohol abuse records, and AIDS testing results.*

Date(s) of Service: **(Last 3 years)** ☐ *All Dates of Service*

☐ **Entire Record**
☐ Copy of Patient's Bill
☐ Cardiology Reports
☐ Other as Specified: _____

☐ Progress Reports / Physician Notes
☐ Radiology Reports
☐ Lab / Pathology Reports

Signatures:

Patient: _____
Legal Guardian: _____
Date: _____

Our Notice of Privacy Practice provides information about our use of a patient's protected health information (PHI). The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to Access, Inspect, and Copy protected health care information used to make decisions about them. The Practice will only include information used to make decisions about the patient. The Practice will limit access to information generated only by this Practice. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold requested information.

Copy Fees: Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the request.

Initial Research/Storage Fee $15.00:	$
Pages 1 – 25 (___ x $1.00 Each):	$
Pages 26 & Up (___ x $.25 Each):	$
Postage:	$
Total Cost *:	$

** Medical Records Fees based on Florida Statues 458.309 FS (455.241, 455.242, & 458.331) amended 5-12-88. Health care providers and facilities may charge for providing copies of medical records:*

- *Initial Research Fee of $15.00*
- *$1.00 per page up to 25 pages*
- *$.25 per page above 25 pages*
- *Actual Postage*

Please make checks payable to: Florida Medical Clinic

FAMILY HISTORY FORM

Patient Name: _____ Date: _____

Please only check if your family member **HAS or HAD** the listed chronic condition:

Condition:	Mother	Father	Brother	Sister	Other
Hardening of Arteries	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐
Color Blind	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐	☐
Eczema: Skin Condition	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Central Loss of Vision	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Migraine Headache	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐

Please Specify Other: _____

PATIENT HISTORY FORM

Patient Name: _____ **Patient DOB**: _____ **Today's Date:** _____

What are you being seen for today? _____

Please Print your current medications and dosage (include prescribed and over counter, vitamins and supplements):

_____

_____

_____

_____

Are you currently being treated for any of the following? (Please circle all that apply)

Diabetes	Thyroid Disease	High Blood Pressure	High Cholesterol	Heart Disease
Asthma	Cancer	Osteoporosis	Kidney Disease	Epilepsy
Stroke	Arthritis	Anemia	Bleeds Easily	Tuberculosis
Headaches	Hepatitis	HIV	Hayfever/Allergies	Depression/Anxiety

Other: _____

Are you currently seeing any other physicians? No Yes If yes, please list: _____

_____

Allergies – (Please list your allergies below and include the type of reaction):
Medications&Reaction: _____
Food:_____ Latex/Other: _____

Surgeries/Accidents/Hospitalizations:(please list and include dates)_____

_____

_____

Family History	**Age**	**Alive/Deceased**	**Medical Issues/Diseases**	**If deceased, cause of death**
Father				
Mother				
Grandparents/Maternal				
Grandparents/Paternal				
Siblings – Brothers # ___				
Siblings – Sisters# ____				
Spouse				
Children # of _____				
Children				
Other:				

Social History

Employer & Occupation: _____
Occupational Exposures Fumes Dust Solvents airborne particles noise

Marital Status: Single Married Separated Divorced Widowed
Alcohol: Never Rarely Moderate Daily Drinks/week/day _____ Type? _____
Tobacco: Never Rarely Frequently… Packs/day _____ Previously but quit when? _____
Caffeine: Never Rarely Frequently… Amt/daily _____ Type: _____
Use of drugs: Never Rarely Previously, but quit, when? _____ Type? _____

Social History (con't)

Patient Name: _____ **Patient DOB:** _____

Do you exercise? ☐No ☐Yes If Yes, How often and what type: _____
Are you sexually active? ☐No ☐Yes
Do you travel outside USA? ☐No ☐Yes If Yes, where: _____
Smoke Detector in your home? ☐No ☐Yes Religion (optional): _____
Do you have a Living Will ☐No ☐Yes Do you have an Advanced Directive ☐No ☐Yes
Do you have any pets? ☐No ☐Yes If Yes, please list type and # _____

Review of Systems

Please indicate any personal & current symptoms below

Constitutional Systems	**Comments**	**Gastrointestinal**	**Comments**
Recent Weight Change ○No ○Yes		Abdominal Pain ○No ○Yes	
Fever ○No ○Yes		Nausea/vomiting ○No ○Yes	
Chills ○No ○Yes		Indigestion/Heartburn ○No ○Yes	
Sleep Disorder ○No ○Yes		Other: _____	
Other: _____			
Eyes		**Respiratory**	
Eye disease/cataracts ○No ○Yes		Wheezing ○No ○Yes	
Wear glasses/contacts ○No ○Yes		Frequent Cough ○No ○Yes	
Blurred/double vision ○No ○Yes		Shortness of Breath ○No ○Yes	
Glaucoma ○No ○Yes		Other: _____	
Other: _____			
Ear/Nose/Throat/Mouth		**Neurological**	
Hearing changes ○No ○Yes		Tremors ○No ○Yes	
Sore throat ○No ○Yes		Dizzy spells ○No ○Yes	
Chronic sinus problems ○No ○Yes		numbness/tingling ○No ○Yes	
Nose bleeds ○No ○Yes		Frequent/headaches ○No ○Yes	
Other: _____		Seizures ○No ○Yes	
		Other: _____	
Cardiovascular		**Integumentary (skin)**	
Chest Pain ○No ○Yes		Rash ○No ○Yes	
Irregular heartbeat ○No ○Yes		Lumps/bumps ○No ○Yes	
Swelling in ankles ○No ○Yes		Moles/skin tags ○No ○Yes	
Murmur ○No ○Yes		Other: _____	
Other: _____			
Endocrine		**Musculoskeletal**	
Excessive thirst ○No ○Yes		Bone pain ○No ○Yes	
Too hot/cold ○No ○Yes		Muscle pain ○No ○Yes	
Tired/sluggish ○No ○Yes		Joint pain ○No ○Yes	
Other: _____		Other: _____	
Hematologic/Lymphatic		**Genitourinary**	
Swollen glands ○No ○Yes		Change in urine stream No Yes	
Blood clotting problem ○No ○Yes		Nocturia (getting up at night) No Yes	
Bruising ○No ○Yes		Urinary frequency >8x/day No Yes	
Other: _____		Other: _____	
Allergic/Immunologic		**Psychological**	
Hay Fever ○No ○Yes		Are you generally happy? ○No ○Yes	
Drug Allergies ○No ○Yes		Do you feel depressed? ○No ○Yes	
Food ○No ○Yes		Do you feel anxious? ○No ○Yes	
Animal ○No ○Yes		Do you feel safe at home ○No ○Yes	
Other: _____		Other concerns: _____	
Sexual History		**Last Exam or Lab tests**	Please enter date (mo/yr)
Change in sex drive ○No ○Yes		Dental: _____	Eye: _____
Sexual performance satisfactory ○No ○Yes		Pelvic: _____	Pap Smear: _____
Sexual Trauma ○No ○Yes		Prostate: _____	PSA: _____
Other concerns: _____		Mammogram: _____	Colonoscopy: _____
		Cholesterol: _____	Stool Tested: _____

Are you here today to review any of the above issues? No Yes If yes please list them: _____

_____

***Any non-urgent issues marked above that are not address today should be addressed in a follow up visit or physical. Your physician will instruct you if a follow up is necessary.**

For Office Use Only:
Dr/PA/NP sig: _____ Date: _____

Florida Medical Clinic
Your life. Our specialty.

Florida Medical Clinic Family Practice - Brandon & Riverview

PHI Consent Brandon

Patient Name _____ Current Date _____

It is our policy to NOT RELEASE confidential and/or unauthorized information, as required by the Health Insurance Portability & Accountability Act of 1996 (Federal Law), by home phone, answering machine, work telephone, voicemail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also NOT be left with an unauthorized person who may answer the telephone.

If you would like to have information released to someone other than yourself please complete the following:

I authorize Florida Medical Clinic - Riverview and its staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes. Mark all that apply

◯ Home _____ ◯ Cell _____ ◯ Work _____

- Office appointment changes/reminders [◯] Y [◯] N
- Information regarding lab and/or outpatient test results [◯] Y [◯] N
- Payment requirements for upcoming appointments [◯] Y [◯] N
- Prescription information [◯] Y [◯] N
- Referral/Specialist appointment information [◯] Y [◯] N
- Billing Information [◯] Y [◯] N
- May we send you a text containing above information. [◯] Y [◯] N
- May we send you an email containing above information. [◯] Y [◯] N

Email Address _____

Are you interested in receiving a secure login to your account via our new Patient Portal? ◯ Y ◯ N

If you have marked yes, your secure log in and password with instructions will be emailed to you at the address listed above. You will receive the information in two separate emails. If you do not wish to have this information emailed please list the best method of contact. _____

May Florida Medical Clinic - Brandon/Riverview fax medical records in the absence of a signed Medical Release form from Attorneys & Social Security *(Please note: Other than your health insurance policy, ALL other requests for medical records WILL REQUIRE A SIGNED CONSENT.)*

[◯] Yes [◯] No

Please list names of people & Date of Birth or last four digits of SS#, so we can discuss your medical care with:

Spouse _____ ◯ Yes ◯ No

Parent _____ ◯ Yes ◯ No

Son/Daughter _____ ◯ Yes ◯ No

Other/Relationship Required _____ ◯ Yes ◯ No

Signature _____ Relationship if other than Patient _____

Florida Medical Clinic – Family Practice
Brandon & Riverview
Prescription Renewal Policy Effective 7/1/2006

You and your family's health is important to us. Our mission is to provide quality coordination of care and implement policies and procedures that will exercise preventative health risk management. Achieving this goal requires a revision of our Prescription Renewal Policy.

Effective July 1, 2006, prescriptions and refills will be issued only by written script during regular office hours. Prescriptions exhausting all available refills will not be renewed without an office visit because of the need to closely monitor their effects. Patients taking maintenance medication(s) will be closely monitored and in most cases be required to have necessary lab work done. Upon assessment and review of necessary laboratory testing your primary care physician will provide enough refills to last through the next required visit or lab testing. A patient whom successfully meets all medical requirements will be granted several refills and then expected to follow up within a period that is based on guidelines and protocols advised for the given medication(s) being prescribed.

PLEASE REMEMBER:

- To schedule a follow up appointment with your physician on the month of your last refill.
- Most Narcotics, Antidepressants, or Class III drugs will NOT receive any refills and require frequent follow up visits. Also please be aware that we **WILL NOT** be responsible for any prescribed narcotics which have been misplaced. Narcotics will not be refilled before your next scheduled visit.
- Please do not call your pharmacy for requests. Their faxes will continue to be disregarded. This practice has been in place since 03/01/2002.
- Patients whom subscribe to a MAIL ORDER Pharmacy must provide the following information: Dispensing Pharmaceutical Co.:_____ Reference#_____ Phone Number: _____

IF YOU HAVE BEEN SEEN IN LESS THAN 2 WEEKS AND REQUIRE CONSIDERATION FOR A "SAME-DAY" PRESCRIPTON OR CHANGE OF MEDICATION, PLEASE LEAVE A MESSAGE WITH A FRONT STAFF MEMBER TO EXPEDITE YOUR REQUEST. PLEASE BE ADVISED THAT A TRIAGE NURSE MAY RETURN YOUR CALL TO REVIEW THE URGENT REQUEST PRIOR TO SEEKING THE RESPONSE FROM THE PHYSICIAN(S) ON-CALL.

_____ _____

Patient's Signature Date

_____ _____

Print Patient's Name Date of Birth