

Atlanta Psychiatric Specialists, P.C.
Ross F. Grumet, M.D.
Conditions of Treatment

OFFICE HOURS: Our office hours are Monday through Friday 9:00 am to 6:00 pm and Saturday 9:30 am to 4:00 pm. We accept appointments from 9:15 am to 5:15 pm Monday thru Friday and from 9:30 am to 3:30 pm on Saturday.

CANCELLATIONS: An automated voice-mail system is available 24 hours a day, 7 days a week for emergency calls or cancellations. **Missed appointments or appointments that are not cancelled at least 24 hours in advance will be charged an administrative fee of \$75.00. This fee is not covered by insurance. We will be unable to schedule any additional appointments until this fee has been paid.**

COMPLETIONS OF FORMS: There is no charge for completing very brief forms indicating therapy, medical visit or school absence. However, completion of most other forms and preparation of reports, medical leave forms, letters of medical necessity, disability etc are subject to fees based on length of the form and determined at the time the form is delivered to the office. Fees for these services are based on copy costs and the amount of time required completing by therapist, physician and administrative staff. **Payment is required before or at the time the forms are completed.**

PRESCRIPTION REFILLS: The Physician prescribes sufficient medication to last until the next visit and therefore requests for refills are generally not expected. The Physician expects to see the patient to be sure the prescription is appropriate, to discuss side effects, etc. **If an appointment is rescheduled or missed and medication is required, we charge a \$35 prescription call in fee. This fee is not covered by insurance and must be paid by the patient before any other services are rendered. Please allow 24 hours for medications to be called in.** While we strive to handle all requests as soon as possible, medication requests require the signature of the ordering physician and therefore there may be a delay in processing.

PAYMENT: It is expected that you pay for sessions at the time of service regardless of your insurance coverage. Any exceptions must be made with the Office Manager prior to session. Services covered by a managed care plan with which Dr. Grumet contracts will be covered per the contractual agreement. However, all medical bills are ultimately the responsibility of the patient. The patient must verify all authorizations and any questions regarding how a claim is processed by an insurance company should be directed to that insurance company, not to our office. **Remember, you are your own best advocate for any insurance issues.**

BILLING: You will receive a statement if there is a balance due. If a statement is needed, please request one at the time of your visit. We reserve the right to assess a finance charge on all balances 120 days past due. Should your account have to be assigned to collections, you will be responsible for all reasonable costs, including attorney's fees. We do not extend credit and the estimated patient responsibility of each visit and/or co-pay and/or deductible amount must be paid at the time of service.

INSURANCE: Most services we provide are covered by most insurance plans. However, because coverage varies widely from plan to plan, we cannot guarantee that your plan will cover your charges. Remember that you are solely responsible for your charges regardless of what your insurance covers, with the exception of a few plans. If you have questions regarding the processing of your insurance claims, please direct those questions to your health insurance plan.

If you have questions or concerns about a business matter, please discuss it with the office manager, Jeff Schade.

Your signature below acknowledges that you have read and accepted these policies. A copy will be given to your for your records upon request. Thank you for your cooperation.

(Signature of patient or authorized person)

(Relationship to patient)

(Date Signed)

(Witness)

Updated 05/09 JPS

NOTICE OF PRIVACY PRACTICES

ATLANTA PSYCHIATRIC SPECIALISTS, P.C.

DR. ROSS F. GRUMET

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. EFFECTIVE APRIL 14, 2003. UPDATED MAY 12, 2009.

If you have any questions about this notice, please contact my Office Manager, Jeff Schade, at 404-685-9414, 1718 Peachtree Street NW, Suite 1080, Atlanta, Georgia, 30309 or email him at jeff@psychiatryatlanta.com

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by healthcare providers you consult with by telephone (when your regular healthcare provider from our office is not available) who provide "call coverage" for your healthcare provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed Consent to use and disclose health information for the following purposes:

For Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel that are involved in taking care of you and your health.

For example, Dr. Grumet may be treating you for a psychiatric condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work, or setting up a referral to another provider. Family members and other healthcare providers may be part of your medical care outside this office and may require information about you that we have.

For Payment. We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Healthcare Operations. We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosure that occur before that time.

If you do revoke your consent, we will not be permitted to use or disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

SPECIAL SITUATION

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence. If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation and Employer Disability Plans. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness and disability.

Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability / or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities. We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal / written agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friend if we can infer from the circumstances, based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the treatment room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURE OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us an Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or healthcare operations, we will have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to Jeff in order to inspect and / or copy your health information. If you request a copy of the information, we may charge a fee to the costs of copying, mailing or other associated supplies. We may deny your request to inspect and / or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment / Correction Form to Jeff. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) If not part of the health information that we keep.
- c) You would not be permitted to inspect and copy.
- d) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to Jeff. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restriction. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about specific items disclosed to Dr. Grumet during treatment.

We are Not Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request for Restriction On Use / Disclosure Of Medical Information / Or Confidential Communication to Jeff.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request For Restriction On Use / Disclosure Of Medical Information And / Or Confidential Communication to the office manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Jeff.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Jeff Schade, Office Manager, at 404-685-9414. You will not be penalized for filing a complaint.

Patient Signature: _____

Date: _____

Witness: _____

A copy of this confidentiality agreement is located in the waiting room for you to review at any time. Please notify the office with any questions.

Atlanta Psychiatric Specialists, P.C.
 Dr. Ross F. Grumet, M.D.
 1718 Peachtree Street NE, Suite 1080
 Atlanta, GA 30309
 Tel: 404-685-9414
 Fax: 404-685-9420
 www.psychiatryatlanta.com

Original Date:	05/2004
Dates Revised:	05/2009

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
 and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	Gender:	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Childhood illness: Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS (INCLUDE MENTAL ILLNESS)		AGE	SIGNIFICANT HEALTH PROBLEMS (INCLUDE MENATAL ILLNESS)
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MENTAL HEALTH CONTINUED

Have you ever been to a counselor or therapist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of counselor or therapist:		
Date of treatment:		
Have you ever had a psychiatric hospitalization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, name of facility and dates of hospitalization:		
Have you ever been under the care of a psychiatrist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, name of provider and dates of treatment:		
Have you ever been prescribed psychiatric medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of medications:		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

Atlanta Psychiatric Specialists, P.C.

Ross F. Grumet, M.D.

1718 Peachtree Street NW

Suite 1080

Tel: 404-685-9414

Fax: 404-685-9420

www.psychiatryatlanta.com

Dispensation

Fax:

Mail out:

Pick up:

Authorization for Release of Confidential Medical Information

Patient Name: _____ SSN: _____

Date of Birth _____ Patient Phone Number _____

Treatment dates to be released _____

Type of Visit Inpatient _____ Out Patient _____ ER _____ Lab _____ Therapy _____ Other _____

This information is to be: Released to _____ Received from _____ Authorization communication with _____

Name: _____ Attn: _____

Address _____

City, State, Zip _____

Phone Number _____

Fax Number _____

Purpose of Disclosure (check one)

- Insurance Personal
- Legal Continuing Care
- Other Specify _____

Portions of Record needed – Check all that apply

- | | | |
|---|--|--|
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> Medication and dosages | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Laboratory Studies | <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Drug/Alcohol Test Results | <input type="checkbox"/> HIV testing/Information |
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> History and Physical | <input type="checkbox"/> Consent Form (Condition of Treatment) |

I hereby authorize Atlanta Psychiatric Specialists and / or Dr. Ross Grumet to release / disclose / receive medical records and / or other information obtained in the course of my diagnosis and treatment. I agree to pay copy charges if applicable for Legal, Insurance and / or Personal Use.

I hereby release Atlanta Psychiatric Specialists and / or Dr. Ross Grumet from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released. I understand that I may revoke this authorization by providing written notice of my intention. Unless withdrawn, this consent will expire 90 days from the date signed.

_____ This information may include Medical / Surgical, Psychiatric, Substance Abuse, and HIV / AIDS information.

_____ I authorize that this information may be faxed to the requesting Health Care Provider.

Patient's Signature: _____ Date: _____

Patient's Representative: _____ Date: _____

Authority to sign on behalf of this patient is authorized by _____

Witness By: _____

Please Note: Records requested for continued care will be mailed / faxed directly to the Doctor / Health Care Provider.