IFMC
Integrated Family Medical Center

Thank You for Becoming a Family Member at Integrated Family Medical Center.

In order to serve you the BEST, we would like you to provide us with the following information.

1. Name of your previous PRIMARY CARE PHYSICIAN. (address/phone/fax number)
i) _____
ii) _____

2. Name of all your SPECIALISTS. (address/phone/fax)
i) _____
ii) _____
iii) _____

3. Your current EMAIL address and PHONE number.
_____

4. Your Pharmacy Name and Address (local and mail order)
i) _____
ii) _____

5. Please bring all your current MEDICATIONS with you.

This way we can request your Medical Records on your behalf and when you come for your FIRST VISIT we will have updated all your records.

Thank you for visiting our office. It will be a pleasure serving you and we hope we can meet all of your needs.

For further communications, please take advantage of the convenience of your **Patient Portal**. Through the portal you can**: request an appointment, request a medication refill**, and **communicate with your Provider or their clinical staff**. It is so easy and convenient. Please give it a try!

We look forward to taking care of you at Integrated Family Medical Center.

Sincerely,

Dr Kalpana Desai, April Weber, APRN and Staff of IFMC.
CR466,Suite 773, Lady Lake, Florida 32159. 352-259-6949
www.Myifmc.com and Drkay@myifmc.com

Kalpana Desai, MD
The Summit of Lady Lake
773, CR 466
Lady Lake, FL - 32159
(352) 259-6949 (P)
(352)-259-1132 (F)
www.myifmc.com

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Patient's Name: _____ D.O.B: _____
Address: _____
City/State/Zip: _____Telephone:_____
Alternate Telephone/Cell: _____ Work: _____
Email Address: _____
Social Security Number: _____ Male: ____Female: ____

PATIENT RESPONSIBILITY:
Person responsible for payment, if other than patient: _____
Relationship to Patient: _____Spouse ____ Parent _____ Employer _____ other: _____
Responsible Person's Address: _____
City:_____ State:_____ Zip: _____
Home Phone: (____) _____ Work Phone :(_____) _____
Date of Birth: _____/____/_____ Social Security#:_____

EMERGENCY CONTACT:
Name: _____ Address: _____
Relationship to Patient: _____ Phone: _____

Minor patients
The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment of services rendered. Non-emergency treatment will be denied to unaccompanied minors unless charges have been pre-authorized to an approved credit plan.

Alternate address for part-time residents
Street Address: _____ City _____
State: _____ Zip: _____ Phone: (_____) _____
How did you hear about us? _____

INSURANCE INFORMATION
Primary:
Name: _____
Policy Number: _____ Telephone: _____
Secondary:
Name: _____
Policy Number: _____ Telephone: _____
Prescription Plan:
Name: _____ ID#_____

_____ _____
Patient Signature: **Date:**

Do you wish to change your Primary Care Physician to Dr. Kalpana Desai MD: (Y / N).
It is your responsibility to make this change with your insurance company for bill purposes.

REASON FOR PHYSICIAN CHANGE: _____

_____

CURRENT PHYSICIANS

Primary Care Provider:
Physician's Name: _____
Address: _____
City/State/Zip: _____
Telephone Number: _____
How long seen: _____

Other:
Physician's Name: _____
Specialty: _____
Address: _____
City/State/Zip: _____
Telephone Number: _____
How long seen: _____

GOALS FOR YOUR VISIT
What concerns would you like for us to address? (Please explain in as much detail as possible)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Consent to Treat
I _____ hereby give **Integrated Family Medical Center** consent to provide whatever treatment deemed necessary for the patient. I hereby authorize the release of medical records and other information as required for payment of benefits payable by insurance or third party sources in connection with treatment of _____ (patient's name). I further authorize payment to be made directly to **Integrated Family Medical Center** of any benefits payable which are otherwise payable to me.

Disclosure/Liability Waiver
Integrated Family Medical Center-Bioidentical Hormone Replacement Program integrates guidelines and practice parameters set forth by the FDA, National Institutes of Health and American Academy of Anti-Aging Medicine. While numerous safety measures are taken by our physicians and staff, incidental events may occur that is beyond the control of our staff. Within the medical community, there are opposing views with respect to the use of bioidentical hormonal therapies. The use of bioidentical hormones does provide true medical benefit, and in this setting is being used to lessen/treat symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bioidentical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You herby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Integrated Family Medical Center, its staff, or treating providers for injury to you on account of involvement in the Bioidentical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this offer.

_____ _____
Patient Signature: **Date:**

FAMILY HISTORY

Is there a history of any of the following conditions in your family? (Parents, siblings)
Please circle one of the following:

Memory Loss	Father	Mother	Siblings
Dementia	Father	Mother	Siblings
Alzheimer's Disease	Father	Mother	Siblings
Cancer, Location?	Father	Mother	Siblings
Heart Disease	Father	Mother	Siblings
High Blood Pressure	Father	Mother	Siblings
Stroke	Father	Mother	Siblings
Chronic Lung Disease	Father	Mother	Siblings
Diabetes	Father	Mother	Siblings
Depression	Father	Mother	Siblings
Parkinson's Disease	Father	Mother	Siblings
Osteoporosis	Father	Mother	Siblings

Mother: Alive/Deceased
Father: Alive/Deceased
Siblings: Alive/Deceased

SOCIAL HISTORY

Circle whatever is applicable

- Employment — Retired Employed
- Marital Status — Married Divorced Widowed Single
- Religious Affiliation: — Yes No
- Do you belong to any social groups? — Yes No
- Do you drive? — Yes No
- Do you use tobacco? — Yes No Quit
- How many Cigarettes do you smoke in a day _____ (day / years)
- Are you willing to quit smoking — Yes No
- Does anyone in your house use tobacco? — Yes No
- Do you drink alcohol? — Yes No Quantity_____
- Have you used any recreational drugs? — Yes No
- Do you drink caffeine? — Yes No
- Are you exposed to the sun? — Frequently Occasionally Rarely

_____ _____

Patient Signature: **Date:**

HEALTH MAINTENANCE

When did you last have the following examination? (Please list date)

1. _____ Dental
2. _____ Vision
3. _____ Hearing
4. _____ Pneumonia vaccine
5. _____ Tetanus vaccine
6. _____ Flu vaccine
7. _____ Shingles vaccine
8. _____ Stool Examination N or Abn
9. _____ Colonoscopy N or Abn
10. _____ Bone Density N or Abnormal

WOMEN'S WELLNESS: (Please list date)

a. _____ Pap smear N or Abn

b. _____ Mammogram N or Abn

c. _____ Hysterectomy

d. _____ Last menstrual period

MEN'S WELLNESS: (Please list date)

PSA blood test (Prostate) _____ Prostate Exam _____

HOSPITALIZATIONS Past hospitalization, Surgeries

1) _____

2) _____

3) _____

4) _____

5) _____

Have you ever had a blood transfusion? _____ YES _____ NO

_____ _____

Patient Signature: **Date:**

PAST MEDICAL HISTORY

- ☐ Abdominal Aortic Aneurysm (441.4)
- ☐ Abnormal Pap Smear (795.00)
- ☐ Abnormal EKG – (794.31)
- ☐ Attention Deficit Disorder (314.0)
- ☐ Allergic Rhinitis (477.9)
- ☐ Anemia (285.9)
- ☐ Anxiety (300.0)
- ☐ Asthma (493.00)
- ☐ Atrial Fibrillation (427.31)
- ☐ Back Pain (724.5)
- ☐ Benign Prostatic Hypertrophy (600.00)
- ☐ Breast Lump (611.72)
- ☐ Bronchitis (491.9)
- ☐ Cancer: Bladder (236.7)
- ☐ Cancer: Breast (239.3)
- ☐ Cancer: Prostate (239.5)
- ☐ Cancer: Skin (239.2)
- ☐ Cancer: Bone (239.2)
- ☐ Cancer: Colon (239.0)
- ☐ Cancer: Lung (239.1)
- ☐ Cancer: Melanoma (172.9)
- ☐ Cardiomyopathy (425.4)
- ☐ Carpal Tunnel (354.0)
- ☐ Cataracts (366.9)
- ☐ Chronic Bladder Infections (595.9)
- ☐ Chronic Diarrhea (787.91)
- ☐ Chronic Pancreatitis (577.1)
- ☐ Chronic Kidney disease (585.9)
- ☐ Congestive Heart Failure (428.0)
- ☐ Constipation (564.00)
- ☐ COPD (496)
- ☐ Coronary Artery Disease (414.00)
- ☐ CVA (434.91)
- ☐ Depression (311)
- ☐ Dementia (294.10)
- ☐ Diabetes (250.00)
- ☐ Diabetes, insulin-dependent (250.01)
- ☐ Diverticulitis (562.11)
- ☐ Diverticulosis (562.10)
- ☐ DVT (453.40)
- ☐ Edema (782.3)
- ☐ Emphysema (492.8)
- ☐ Erectile dysfunction (607.84)
- ☐ Gallbladder Disease (575.9)
- ☐ GERD (530.81)
- ☐ Genital Herpes (054.10)
- ☐ Gout (274.9)
- ☐ Hearing Impairment (389.9)
- ☐ Headache (784.00)
- ☐ Heart Disease (429.9)
- ☐ Heart Murmur (785.2)
- ☐ Hernia (550.90)
- ☐ History of Breast Cancer (V10.3)
- ☐ History of Prostate Cancer (V10.46)
- ☐ Hypertension (401.9)
- ☐ Hypothyroidism (244.8)
- ☐ Hyperlipidemia (272.4)
- ☐ Iron Deficiency Anemia (280.9)
- ☐ Insomnia (780.52)
- ☐ Kidney Stones (592.0)
- ☐ Macular Degeneration (362.50)
- ☐ Memory Impairment (780.93)
- ☐ Migraine Headache (346.90)
- ☐ Mitral Valve Prolapse (424.0)
- ☐ Morbid obesity (278.01)
- ☐ Osteopenia (733.90)
- ☐ Osteoporosis (733.00)
- ☐ Osteoarthritis (715.98)
- ☐ Obstructive Sleep Apnea (327.23)
- ☐ Other protein calorie and malnutrition (263.8)
- ☐ Palpitations (785.1)
- ☐ Peripheral Arterial Disease (443.9)
- ☐ Pneumonia (486)
- ☐ Pulmonary Nodule (518.89)
- ☐ Pulmonary Embolus (415.19)
- ☐ Polycythemia (289.0)
- ☐ Rheumatoid Arthritis (714.0)
- ☐ Restless leg syndrome (333.94)
- ☐ Seizures (780.39)
- ☐ Stasis Edema (459.30)
- ☐ Thyroid Nodule (241.0)
- ☐ Ulcers (707.9)
- ☐ Urinary Incontinence (788.30)
- ☐ Uterine Prolapse (618.1)
- ☐ Varicose Veins (454.9)
- ☐ Vitamin B12 Deficiency (266.2)
- ☐ Vitamin D Deficiency (268.9)

_____

Patient Signature:

_____

Date:

Current Review of You over the last Two Weeks

Please circle Y or N when completing this section.

General Symptoms

Weight Loss	Y or N	Weight Gain	Y or N
Fever	Y or N	Chills	Y or N
Sweats	Y or N	Cold or Flu	Y or N
Change in Appetite	Y or N		

Eyes

Glaucoma	Y or N	Macular Degeneration	Y or N
Cataract	Y or N	Problems w/ eyeglasses	Y or N
Trouble Seeing	Y or N	Eye Pain	Y or N

Ear, Nose, Mouth, Throat

Trouble Hearing	Y or N	Ear Pain or Itching	Y or N
Sinus Problems	Y or N	Nose Bleeds	Y or N
Sore Throat	Y or N	Teeth/ Denture Problem	Y or N
Hoarseness	Y or N	Mouth Sores	Y or N
Problems Chewing	Y or N	Dry Eyes	Y or N

Heart

Heart Attack	Y or N	Pacemaker	Y or N
CHF	Y or N	High Blood Pressure	Y or N
Low Blood Pressure	Y or N	Swelling of Feet	Y or N
Chest Pain/Tightness	Y or N	Rapid/Irr Heart Beat	Y or N

Lung

Trouble Breathing(am)	Y or N	Perspiration	Y or N
Persistent Cough	Y or N	Coughing up blood	Y or N
Wheezing	Y or N	Asthma	Y or N
Bronchitis	Y or N	Emphysema	Y or N
Cancer	Y or N	Trouble breathing (pm)	Y or N

Digestion

Difficulty Swallowing	Y or N	Indigestion	Y or N
Nausea/Vomiting	Y or N	Heartburn	Y or N
Change in BM	Y or N	Black BM	Y or N
Bleeding from Rectum	Y or N	Stomach Ache	Y or N

Patient Signature: _____ **Date:** _____

Bone and Joint

Leg Pain on walking	Y or N	Rheumatoid Arthritis	Y or N
Back/Neck pain	Y or N	Osteoporosis	Y or N
Joint Pain/Stiffness	Y or N	Fracture	Y or N
Foot Problem	Y or N	Gout	Y or N
Arthritis	Y or N	Osteoarthritis	Y or N

Brain and Nervous System

Frequent Headaches	Y or N	Problem w/ Sleep	Y or N
Balance	Y or N	Stroke-TIA	Y or N
Alzheimer's	Y or N	Dementia	Y or N
Seizure	Y or N	Frequent Dizzy Spells	Y or N
Parkinson's Disease	Y or N	Passing Out/Fainting	Y or N
Paralysis	Y or N	Falls	Y or N
Tremor/Shaking	Y or N	Memory/Thinking	Y or N

Mood/Sadness:

Depression	Y or N	Anxiety	Y or N
Hallucinations	Y or N	Agitation	Y or N

Kidney and Urinary Tract Problems:

Blood in Urine	Y or N	Loss of Urine	Y or N
Frequent Urination	Y or N	Urination at night	Y or N
Painful Urination	Y or N	Kidney Disease	Y or N
Prostate Disease	Y or N	Frequent Infection	Y or N
Diff starting/stopping	Y or N		

Gynecological Problems (Women):

Pain	Y or N	Itching	Y or N
Discharge	Y or N	Bleeding	Y or N

Skin

Rash	Y or N	Sores	Y or N
Itching	Y or N		

Miscellaneous and Others

Excessive Thirst	Y or N	Excessive Hair	Y or N
Feel Too Hot	Y or N	Polycycstic Ovaries	Y or N
Sexual Functions	Y or N	Hormonal Problems	Y or N
Blood Clot	Y or N	Thyroid	Y or N
Anemia	Y or N	Adrenal	Y or N
Cancer	Y or N	Diabetes I or II	Y or N
Other	Y or N	Diabetes	Y or N
Gland Problems	Y or N	Underactive Thyroid	Y or N
Overactive Thyroid	Y or N		

Patient Signature: _____ **Date:** _____

MEDICATION LIST				
Patient Name:_____, _____			Date of Birth:_____	
Pharmacy:_____		Pharmacy Phone #:_____ Pharmacy Fax #_____		
Allergies to Medications: 1. _____ 2. _____ 3. _____		4. _____ 5. _____ 6. _____		
Date prescribed	**Medication**	**Dose**	**Quantity**	**Frequency**

NOTE: _____

_____

_____

_____

_____

_____ _____

Patient Signature: Date:

OFFICE FINANCIAL POLICY

1. As a courtesy, we will file your primary and secondary insurance. It is your responsibility to make sure that your insurance company has Dr. Kalpana Desai MD listed as your primary care physician and your most recent address and contact information.
2. We are required to make a copy of your insurance cards for verification purposes.
3. We will collect your deductible, co-payment and uncovered service fees at the time of service. Payment methods are: Cash, Check, MasterCard, Visa, American Express, Discover.
4. **Appointments cancelled less than 24 hours of the set appointment time are subject to a $75.00 cancellation fee. Initials_____**
5. **A cancellation of Ultrasound, PFT less than 48 hours before the appointment time is a $75.00 cancellation fee and requires a verbal conversation with Dr. Deasi. Initials_____**
6. **A cancellation of a Stress test less than 48 hours before the appointment time is a $175.00 fee and requires a verbal conversation with Dr. Deasi. This fee covers the cost of the nonrefundable pharmaceutical. Initials_____**
7. All copies of Patient Documents are $1.00 per page.
8. Your insurance will send you an explanation of benefits that explains what they have paid to our office. This is a record that you **MUST** keep on file. If you do not agree with their payment, please contact the insurance company directly...
9. If payment is not received within 30 days of the filing date with your insurance, you will be notified that payment is due.
10. If you are sent outside of the office for additional testing such as lab work or imaging, that facility will file your insurance for you. If you have questions regarding billing or claim payment, call the facility directly. We do not have information regarding billing from outside of this office.
11. Patient will be responsible for all collection costs incurred by Integrated Family Medical Center in the recoupment of unpaid balances.

_____ _____

Patient Signature: **Date:**

PHONE MESSAGE POLICY

I acknowledge and agree that the ***Integrated Family Medical Center*** may: (CHECK ALL THAT APPLY)

- ☐ Leave a message regarding upcoming appointments
- ☐ Leave a message regarding lab results/imaging studies/medication refills on my home answering machine
- ☐ Leave a message regarding billing questions on my home answering machine

I acknowledge and agree that Integrated Family Medical Center may disclose my protected health information and medical record information to the following individuals who are either, my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

Print name	Relation	Phone
Print name	Relation	Phone
Print name	Relation	Phone

I have read and understand the information in this consent. I may receive a copy of this consent if I so choose and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

Signature of Patient or Authorized Representative: _____

Please Print Name: _____ Date: _____

ADVANCE DIRECTIVES

Do you have the following? Please Circle **Yes** or **No**.

1. Yes No - Living Will.
2. Yes No - Advance Directives.
3. Yes No - Do Not Resuscitate.
4. Yes No - Durable power of Attorney.

Name: _____ Relation: _____ Phone: _____

5. Yes No -HealthCare Surrogate.

Name: _____ Relation: _____ Phone: _____

_____

Signature of Patient or Legal Guardian Date

_____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

PRESCRIPTION REFILL POLICY

Refills for current medications can be accomplished by:

1. Allow **48-72** hours for processing of refill request.
2. Call your pharmacy and have them fax a refill request.
    a. Bio-identical hormone replacement prescriptions require payment before these can be refilled.
    b. Bio-identical hormone replacements are only filled through our office.
3. Calling your pharmacy and requesting an electronic transmission request be sent for needed refills
4. Keeping an up to date list of needed prescription refills and requesting them at the time of your appointment

PLEASE NOTE:

1. Refill requests received from a pharmacy will be accomplished within **48-72** business hours.

2. Please do not leave multiple requests for the same medication!

3. If you are completely out of a medication you can contact your pharmacy for an emergency refill (typically 3-4 days worth of the medication).

4. Drop in and call in requests for prescription refills will be manually entered into the system at the end of the business day and subject to a **48-72** business hour wait period from that time.

5. Your physician will not be pulled out of a room while seeing a patient to refill any medications as this is not fair to patients with scheduled appointments.

6. Refill requests received through the patient portal will be accomplished within **48-72** business hours.

7. We do not fax prescriptions to mail order pharmacies these will have to be picked up in person.

Signature of Patient or Legal Guardian:

Patient's Signature: _____ Date: _____

Print Name of Patient: _____

Legal Guardian Signature: _____ Date:_____

Print Name of Legal Guardian:_____

Instructions for Completing
HIPAA Privacy Authorization Form

If you would like some person other than yourself to have access to your medical records and information, and allow health care providers to release such information to that person, you must authorize the release of the information in writing. Since a Durable Power of Attorney for Health Care is only effective after you have lost your capacity to make or communicate decisions, the Power of Attorney does not authorize release of medical information to the person named while you remain competent. If you want some person other than yourself to have access to that information now, while you remain competent, you need to complete and sign a HIPAA Privacy Authorization Form, regardless of whether or not you also have a Durable Power of Attorney for Health Care in place.

In **Section** 1 you need to insert the name of the health care provider (hospital, physician, etc.) who is authorized to release the information, and the name of the person who is authorized to receive the information.

In **Section** 2 you first need to indicate what **time period** is covered by the authorization, and then what type of information is allowed to be released.

In **Section** 4 you need to indicate **how long** the authorization is to remain effective, for example until a certain date or until your death. You retain the power to revoke the authorization at any earlier time.

The form needs to be **signed** by the patient or by the personal representative of the patient, such as a parent if the patient is a minor. You must complete a separate form for each health care provider you want to authorize to release information. We suggest you photocopy the form for multiple use.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

I hereby authorize _____ to use and/or disclose the protected
[Name of Health Care Provider]

health information described below to **Integrated Family Medical Center** OR_____.
[Name of Individual]

1. Authorization for Release of Information. Covering the period of health care from
[ ] _____ to _____ OR [ ] All past, present and future periods:

a. [ ] I hereby authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of Alcohol/ drug abuse).

OR

b. [ ] I hereby authorize the release of my complete health record with the exception of the following information:

[ ] Mental health records
[ ] Communicable diseases (including HIV and AIDS)
[ ] Alcohol/drug abuse treatment
[ ] Other (please specify): _____

2. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

3. This authorization shall be in force and effect until _____at which time this authorization expires.
[Date or Event]

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship to Patient

IFMC
Integrated Family Medical Center

Kalpana Desai, MD
The Summit of Lady Lake
773 CR 466
Lady Lake, FL 32159
352.259.6949 (O)
352.259.1132 (F)

Medical Information Release Request

I hereby authorize the Practice, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of: Patient name: _____

Address: _____
(Street) (City) (State) (ZIP)

Date of birth: _____ Date(s) of treatment: _____

From: _____
(Provider Name) (Address) (Phone) (Fax)

To: **Integrated Family Medical Center, Kalpana Desai, MD**
The Summit of Lady Lake, 773 CR 466, Lady Lake, FL 32159 P: 352.259.6949 F: 352.259.1132

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ All Notes from recent Hospitalization or Outpatient Care
_____ All Notes from Emergency Room Visit
_____ All Notes from Medical Treatment
_____ Last Consult Notes/Progress Notes
_____ Other: _____
_____ Entire Medical Record
_____ Labs
_____Diagnostic Tests/Imaging Reports

I permit this confidential information to be released for the following purpose:

_____ Continuing Medical Treatment _____ Litigation for Review
_____ Insurance (company name): _____
_____ Other (specify reason): _____

This consent permits the Practice to use and disclose my health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____ (Print patient's name)

_____ (Signature of patient)

_____ (Signature of Legally Guardian)

If there are questions, please contact us at [352-259-6949].