North San Antonio:
8626 Tesoro Dr., Ste 112, San Antonio, TX 78217

South San Antonio:
137 SW Military Dr., San Antonio, TX 78221

Quantum Pain and Orthopedics
Tel: **210-817-6010**
Fax: **210-817-6011**
Email: **Info@QuantumPainOrtho.com**
www.QuantumPainOrtho.com

Patient Name (First Name, Middle Name, Last Name):	Date of Birth:	Home Phone:	Mobile Phone:	☐ New Patient ☐ Updated Information Date: ____/____/____
Address:	Social Security Number:	Sex: M ☐ F ☐	Marital Status: *(Please circle one)* Singe Married Other	
City, State, ZIP	Age:	DL #:	Email Address:	

(Please check one)
Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ Black ☐ Caucasian ☐ Pacific Islander ☐ Other ☐ Declined

(Please check one)
Ethnicity: ☐ Hispanic ☐ Non- Hispanic ☐ Declined

(Please check one) Language: ☐ English ☐ French ☐ Korean ☐ Spanish ☐ Vietnamese ☐ Other: ____________

Employer Name:	Occupation:	Address:	Work Phone Number:

Emergency Contact/Authorized HIPAA Contact Information

Emergency Contact Name: ______________________ Relationship to Patient: ______________ Phone: ____________________

Primary Care Physician: ______________ Phone: ______________ Referring Physician: ______________ Phone: ______________

Preferred Pharmacy

Pharmacy Name: ______________ Phone: ______________ Address: __________________ City/State/Zip: __________________

Primary Insurance

Who is the Primary Insured Party (Check one): ☐ Patient (same as above) ☐ Spouse ☐ Other (complete below) **(Please give your insurance card to the receptionist)**

Insured's Name (First Name, Middle Name, Last Name):		Insurance Company Name:	
Insured's Address: City/State/Zip:		Insurance Company Address: City/State/Zip:	
Insured's Policy Number: Group #:		Insurance Company Phone Number:	
Insured's Date of Birth:	Insured's Social Security No.	Insured's Sex: ☐ Male ☐ Female	Patient's relation to insured:

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

Legal Assignment of Benefits and Designation of Authorized Representative

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Quantum Spine and Orthopedic, PLLC as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand that I am financially responsible for all changes regardless of any applicable insurance or benefit payments. I hereby authorize the above-named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies, I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider(s), to the full extent permissible under the law and under any applicable employee group health plan(s), insurance policies or liability claim, any claim, chose in action, or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer)s) under any applicable insurance policies, employee benefits plan(s) or public policies with respect to medical expenses incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the law to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making settlements about facts or law; (4) making any request, or giving , or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

______________________	______________________	______________________
Patient/Guardian Signature	***Print Name***	***Date***

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Patient Information

______________________________ ______________________

Patient's Full Name (First, Middle, Last) **Date of Birth**

History of Present Pain

What is the cause of your Injury/Pain: ☐ Work Injury ☐ Slip and Fall If slip/fall, where did the slip/fall occur? ______________

☐ Auto Accident ☐ Other (explain) ______________________

When did your Injury/Pain occur? (Date) ______________

How long have you experienced this pain? ________ Years ________ Months ________ Weeks ________ Days

****If this is a result of a Work Injury, please fill out the following information:**

Injury from: ☐ Falling ☐ Lifting ☐ Twisting ☐ Bending ☐ Pulling ☐ Reaching ☐ Other (Describe): ______________

****If this a result of an Auto Accident, please fill out the information below:** ***Please circle one***

Did the airbags deploy? YES / NO

Were you wearing your seatbelt? YES / NO

Were you the: Driver / Passenger / Pedestrian

Was there a police report filed? YES / NO

Did you go to the ER? YES / NO If so, Name of the facility: ______________ Location/Address: ______________

Did you perform any Imaging for your current pain? YES / NO **If yes, please check all the studies that have been performed below:**

☐ XRAY Date(s): ________ ☐ CT SCAN Date(s): ________ ☐ MRI Date(s): ________ ☐ Other: ______________

☐ I have not had any diagnostic imaging performed for my current pain complaints ☐ Unknown

Have you had previous treatment(s)? YES / NO **If yes, please fill out the following below:**

Have you had any of the following treatments?

Spinal Epidural Steroid Injection: YES / NO **If yes, did it make you feel better or worse?** ______________

What type of Injections and when was the treatment date? ______________________

Chiropractic: YES / NO **If yes, did it make you feel better or worse?** ____________ Are you still treating? YES / NO

How many weeks or visits have you treated with Chiropractic? ____________

Physical Therapy YES / NO **If yes, did if make you feel better or worse?** ____________ Are you still treating? YES / NO

How many weeks or visits have you treated with Physical Therapy ____________

Pain Medications? YES / NO **If yes, did they help?** YES / NO What Medications? ______________________

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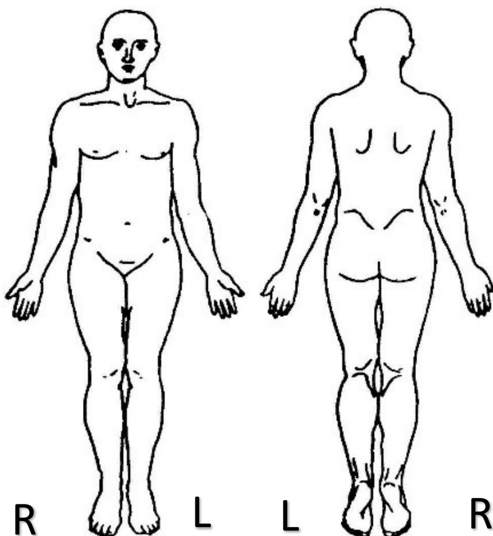
Symptom Description

1. Where is your pain? ______________________
2. Is your pain: ☐ Sharp ☐ Dull ☐ Burning ☐ Pulling ☐ Shooting ☐ Aching ☐ Throbbing ☐ Stabbing
3. Do you have associated symptoms of: ☐ Numbness ☐ Tingling ☐ Cramping ☐ Decreased sensation ☐ Weakness or clumsiness

   Other Type of Pain (Describe): ______________________
4. Does your pain limit your mobility? YES / NO
5. Does your pain feel like it travels from your back to your legs? YES / NO If so, which side? LEFT / RIGHT
6. Does your pain feel like it travels from your neck to your arms? YES / NO If so, which side? LEFT / RIGHT
7. Did your pain start: ☐ Gradually (Slowly) ☐ Suddenly (Immediately)
8. Are your symptoms: ☐ Constant ☐ Intermittent (Comes and goes)
9. Are your symptoms getting: ☐ Better ☐ Worse ☐ Unchanged
10. What makes your pain better? ______________________
11. What makes your pain worse? ______________________
12. Rate the severity of your pain right now: **(0 = None / 10 = Worst)** ***Please circle one***

    0 1 2 3 4 5 6 7 8 9 10
13. Using the pain scale (0-10), best describe the level of your pain at its ***worst:*** __________
14. Using the pain scale (0-10), best describe the level of your pain at its ***least:*** __________



Use the diagram to show where you have your pain. Mark the area with an **(X)** that best describes your pain location:

______________________ ______________________ ______________________

Patient/Guardian Signature ***Print Name*** ***Date***

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Past Medical History: Have you been diagnosed with any of the following conditions? ***Please check the box(es) below if applicable:***

□ Hypertension	□ Heart Disease	□ Vascular Disease	□ Heart rhythm disturbance
□ Poor Circulation	□ Stroke	□ Epilepsy	□ Multiple Sclerosis
□ Diabetes	□ Osteoporosis	□ Cancer	□ Malignant hyperthermia
□ Latex allergy	□ Difficult anesthesia	□ Pulmonary Disease	□ TB
□ Lung Blood Clot	□ Leg Blood Clot	□ Bacteraemia	□ Serious Infection
□ Colon Problems	□ Swallowing difficulty	□ Liver Disease	□ Blood clotting disorder
□ Anemia	□ Immune disorder	□ Hepatitis	□ HIV or AIDS
□ Nickel allergy	□ Depression	□ Anxiety	□ Psychosis
□ Asthma			

Please list any other conditions not mentioned above:

Past Surgical History:

Family History:
Is there a family history of the following conditions?
□ Heart Disease □ Stroke □ Scoliosis □ Cancer
□ Diabetes □ Anesthetic problems □ Blood disorder
□ Hypertension □ Epilepsy

Please list any other conditions not mentioned in Family History:
____
____

Occupation? ____________________________________
Does work involve lifting? □ Yes □ No □ Some

Unable to work because of your pain □ Yes □ No
On disability: □ Yes □ No How long? ________

Sometimes it is difficult to do my job because of pain:
☐ Yes ☐ No

Smoker □ Yes □ No If yes, how many per day? ____ Smoked for how many years total? ________

Drinker □ Yes □ No □ Drink rarely □ Drink socially □ Drink daily □ Drink heavily

Drug or narcotic addiction □ Yes □ No
Use of non-prescription narcotics □ Yes □ No

Psychiatric illness of any kind □ Yes □ No
If yes, please give details:

Medications:
Please list medications, doses and how often you take them. If there is not sufficient space please attach on a separate sheet.

Are you taking any non-prescription medication at all? E.g., vitamins, herbs, health supplement. If so, please list them as these may sometimes affect you during any surgery:

Allergies: □Yes □ No If yes, please list allergies to any medications, metals or latex:

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SOAPP® Version 1.0 – SF

Patient Name: ____ Date: _______________

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions by checking the boxes that apply:

Question	0. OFTEN	1. SELDOM	2. SOMETIMES	3. OFTEN	4. VERY OFTEN
1. How often do you have mood swings?					
2. How often have you felt that things are just too overwhelming that you can't handle them?					
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?					
4. How often have you had suicidal thoughts?					
5. How often have others suggested that you have a drug or alcohol problem?					
6. How often have you taken medication other than the way that it was prescribed?					
7. How often have you been treated for an alcohol or drug problem?					
8. How often have your medications been lost or stolen?					
9. How often have other expressed concern over your use of medication?					
10. How often have you felt a craving for medication?					
11. How often have you been asked to give a urine screen for substance abuse?					
12. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?					
13. How often have you had to borrow pain medications from your family or friends?					
14. How often, in your lifetime, have you had legal problems or been arrested?					

Please include any additional information you wish about the above answers. Thank you. *TOTAL:* ______

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ___________________________________ hereby authorize Quantum Pain and Orthopedic to (release / obtain) healthcare information of the patient below to:

___________________________________ ___________________________________

Person or Organization: Address (City, Zip):

___________________________________ ___________________________________

Phone: Fax:

Requesting information/copies for medical records on:

____ ___________________________________

Patient (First, M, Last Name) Date of Birth:

Date of Service(s): ____

The request and authorization applies to:

☐ All healthcare information

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ Yes ☐ No I authorize Quantum Pain and Orthopedics to obtain/furnish to/from any consulting physician or insurance company and its representatives, any information and/or copies of all medical records, consultations, and prescriptions relating to illness. In addition, I grant permission to view my prescription history from external sources. A copy of this authorization shall be effective and valid.

☐ Yes ☐ No I authorize the release of any records regarding imaging reports, medical notes, and operative reports.

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): ____/____/____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of heath information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154 © and/or 45 C.F.R 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

___________________________________ ___________________________________

Signature: Date:

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Patient Information

Full Name (First Middle Last):	Date of Birth: (MM/DD/YYYY) _____ / _____ / _________

Patient Agreement for Prescription Opioids

The purpose of this agreement is to structure our plan to work together to treat your chronic pain. This will protect your access to controlled substances and our ability to prescribe them to you.

I (patient) understand the following:

- Opioids have or will be prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including returning to work or school. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.
- Opioids are being prescribed to make my pain tolerable but may not cause it to disappear entirely. If that goal is not reached, my physician may end the trial.
- Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle nor perform other tasks that could involve danger to myself or others.
- Using opioids to treat chronic pain will result in the development of a physical dependence on this medication, and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms can include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, aches and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.
- There is a small risk that opioid addiction can occur. Almost always, this occurs in patients with a personal or family history of other drug or alcohol abuse. If it appears that I may be developing addiction, my physician may determine to end the trial.
- (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.
- (Females only) If I plan to become pregnant or believe that I have become pregnant while I am taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon opioids. I am aware that the use of opioids is not generally associated with risk of birth defects; however, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking an opioid.

I agree to the following:

- I agree not to take more medication than prescribed and not to take doses more frequently than prescribed.
- I agree to keep the prescribed medication in a safe and secure place, and that lost, damaged, or stolen medication will not be replaced.
- I agree not to share, sell, or in any way provide my medication to any other person.
- I agree to obtain prescription medication from one designated licensed pharmacist. I understand that my doctor may check the Texas Prescription Monitoring Program at any time to check my compliance.
- I agree not to seek or obtain ANY mood-modifying medication, including pain relievers or tranquilizers from ANY other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription except from another prescriber, I will advise that prescriber of this agreement, and immediately advise my prescriber that I obtained a prescription from another prescriber.
- I agree to refrain from the use of ALL other mood-modifying drugs, including alcohol, unless agree to by my prescriber. The moderate use of nicotine and caffeine are an exception to this restriction.
- I agree to submit to random urine, blood or saliva testing, at my prescriber's request, to verify compliance with this, and to be seen by an addiction specialist if requested.
- I agree to attend and participate fully in any other assessments of pain treatment programs which may be recommended by the prescriber at any time.

I understand that ANY deviation from the above agreement may be grounds for the prescriber to stop prescribing opioid therapy at any time.

_______________________________ _____________________

Patient Signature Date

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NOTICE OF OUR PRIVACY PRACTICES

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMUNITY TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information **(IIHI)**. In conducting our business, we will create records regarding you and your treatment and the services we provide for you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize that these laws are complicated, but we must provide you with the following important information:

1. How we may use and disclose your IIHI.
2. Your privacy rights in your IIHI.
3. Our obligations concerning the use and disclosure of your IIHI.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Quantum Pain and Orthopedics
8626 Tesoro Drive, Suite 112 San Antonio, TX 78217
137 Southwest Military Drive, San Antonio, TX 78221

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS.

The following categories describe the different ways in which we may use and disclose your IIHI:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Any of the people who work for our practice - including, but not limited to, our doctors and nurses, or indirectly with any provider we refer you to - may use or disclose your IIHI in order to treat you, or to assist others in your treat. Additionally, we may need to disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits0, and we may provide your insurer with details regarding your treatment and health status to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members or insurance companies. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduce cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you or a family member who answers the phone (or to leave a recorded message) to remind you of an upcoming appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to our office for care. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES.

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

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1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths.
   - Reporting child abuse or neglect.
   - Preventing or controlling disease, injury or disability.
   - Notifying a person regarding potential exposure to a communicable disease.
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition.
   - Reporting reactions to drugs or problems with products or devices.
   - Notifying individuals if a product or device they may using has been recalled.
   - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.

2. **Heath Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensures and disciplinary actions, civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may disclose use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. In general, we will require that the party that requests your records provide a records-release form, signed by you within the last 3 months.

4. **Law Enforcement**. We may release IIHI if asked to do so by law enforcement official:

   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
   - Concerning a death, we believe has resulted from criminal conduct.
   - Regarding criminal conduct at our offices.
   - In response to a warrant, summons, court order, subpoena or similar legal process.
   - To identify/locate a suspect, material witness, fugitive or missing person.
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator).

5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for the funeral directors to perform their jobs.

6. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional review board or a Privacy Board; (b) we obtain the oral or written agreement of a research that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any your IIHI from our practice; or (c) the IIHI sought by the research only relates to descendants and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research, and if we request it, to provide us with proof of death prior to access to the IIHI of descendant's.

7. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. **Military.** Our practice may disclose your IIHI if you are member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

10. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcements officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or, (c) to protect your health and safety or the health and safety of other individuals.

11. **Workers' Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

I have received or reviewed the privacy practice notice (2 pages) for Quantum Pain and Orthopedics, and understand the situations in which this practice may need to utilize or release of my medical records. I also understand that I agreed to the use of those records when initially applied for care at this office.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_______________________________	_____________________________	_____________________________
Print Patient Name	Patient Signature	Date