TPCA Tallahassee Primary Care Associates

PATIENT'S PERSONAL HISTORY

DATE: ______________

FULL NAME: ____ DATE OF BIRTH: ____________________

REFERRING PHYSICIAN: ______________________________

REASON FOR VISIT TODAY'S VISIT ____

MARITAL STATUS: ____________________ OCCUPATION: ______________________________

DO YOU HAVE ANY CHILDREN? ____

LIST SURGICAL PROCEDURES	CURRENT MEDICATIONS	DOSE

MEDICATION ALLERGIES	REACTION

SMOKING ______ YES ______ QUIT WHEN DID YOU STOP? ______________

______ NO ______ # OF CIGARETTES PER DAY

ALCOHOL ______ YES ______ QUIT

______ NO ______ # OF DRINKS PER DAY TYPE OF ALCOHOL ____________

EXERCISE ______ YES ______ NO ______ MINUTES PER DAY, ________ DAYS PER WEEK

DESCRIBE YOUR DIET: ____

SERVINGS OF CAFFEINE PER DAY: ________________

SUBSTANCE ABUSE: ☐ YES ☐ NO DESCRIBE: ____

Kristin Harmon, MD – Katherine Owen, APRN – 2623 Centennial Blvd, Suite 204 - Tallahassee, FL 32308
850-702-5007 phone - 850-219-1059 fax

CHECK ALL THAT APPLY AND EXPLAIN BRIEFLY:

___ DIABETES ________________
___ SKIN PROBLEMS ________________
___ HIGH BLOOD PRESSURE ________________
___ HEART DISEASE ________________
___ ARTHRITIS ________________
___ THYROID DISEASE ________________
___ CANCER ________________
___ STOMACH ULCERS ________________
___ KIDNEY DISEASE ________________

___ HEARTBURN ________________
___ LIVER DISEASE ________________
___ ANEMIA ________________
___ NEUROLOGIC DISEASE ________________
___ BLOOD CLOTS ________________
___ SEIZURES ________________
___ OTHER MEDICAL PROBLEMS:

____

____

FAMILY HISTORY	TYPE OF DISORDER	FAMILY RELATIONSHIP
___ DIABETES	________________	________
___ THYROID DISEASE	________________	________
___ HEART DISEASE	________________	________
___ HYPERTENSION	________________	________
___ STROKE	________________	________
___ CANCER	________________	________
___ CHOLESTEROL OR LIPID DISORDER	________________	________
___ OSTEOPOROSIS	________________	________
___ ABNORMAL CALCIUM	________________	________
___ KIDNEY STONES	________________	________
___ PITUITARY OR ADRENAL TUMOR	________________	________
___ OTHER	________________	________

MOTHER LIVING: _______ YES _______ NO MEDICAL PROBLEMS: ________________

FATHER LIVING: _______ YES _______ NO MEDICAL PROBLEMS: ________________

FOR PATIENTS WITH DIABETES ONLY

DURATION OF DIABETES ________________ AGE AT ONSET ________

CURRENT TREATMENT REGIMEN ORAL AGENTS: ________________

INSULIN: ________________

DO YOU HAVE A GLUCOSE METER? _______ YES _______ NO

HOW OFTEN DO YOU CHECK GLUCOSES? ________________

ANY COMPLICATIONS WITH YOUR DIABETES (CHECK ALL THAT APPLY)

___ EYE PROBLEMS
___ KIDNEY PROBLEMS
___ NERVE DAMAGE
___ HEART ATTACK

___ ANGIOPLASTY (DATE: ____________)
___ FOOT ULCER (DATE: ____________)
___ BYPASS SURGERY (DATE: ____________)

MOST RECENT STRESS TEST: ________

MOST RECRNT EYE EXAM: ________

OFFICE INFORMATION – Kristin Harmon, MD

APPOINTMENT CANCELLATIONS/NO SHOWS:

- We ask for 24 hour notice for appointment cancellations so that we may have an opportunity to schedule someone from our wait list.
- No Shows and Cancellations that occur less than 24 hours before your appointment time may incur a **$45 fee**. If your appointment is on Monday, this would require you to call us on Friday during business hours to cancel.
- If you have not been able to complete your pre-clinic testing (labs, radiology) the providers usually prefer for you to go ahead and come to your follow-up appointment anyway. Results can be shared via phone or portal after the appointment if needed.

LATE POLICY:

- We ask that patients arrive 15 minutes prior to their appointment time. Ideally, this allows for check in time, demographics verification and intake by the clinical staff so that each patient may start their appointment as close to their appointment time as possible.
- If you arrive more than 15 minutes past your appointment time we will make every effort to work you back into that day's schedule, but we may be forced to reschedule you to another date/time depending on patient load for that day.

PATIENT PORTAL:

- We recommend that all patients sign up for the patient portal at www.tallahasseeprimarycare.com
- This allows you to see your appointment schedule and test results (especially when performed at the TPCA facility) and allows for easier communication with staff via messaging.

REFILL REQUESTS:

- Please contact your pharmacy first for any refill requests.
- It may take up to 72 hours for your refill request to be processed, especially if it is a controlled medication.

MEDICATIONS:

- If actively followed in this clinic, you will need to have follow-up appointments & lab work on a regular basis. This timeframe is established by the provider based on your diagnosis, symptoms, and medications in order to help you in the safest, most effective way possible. Please understand that we may not be able to fill your medications if you have not been seen – This is for your safety.

MD/NP/PA:

- My practice uses a variety of professional healthcare providers in order to provide patients with the best and most timely care. Some of these providers include (but are not limited to): Endocrinologist (MD), advanced registered nurse practitioner (ARNP), physician's assistant (PA), certified diabetes educator (CDE), registered nurse (RN), licensed practical nurses (LPN), and certified medical assistants (CMA/RMA). While all of these individuals may be involved in your care, patient care is always overseen by a medical doctor. These individuals work together as a team to improve and provide comprehensive patient care. If you join this practice, your appointment may be with an ARNP or PA and not with the MD, but all care is collaborative even if you are not physically seeing the MD that day. If this type of practice does not work for you, then unfortunately we will be unable to meet your needs

Patient Signature: ______________________________ **Today's Date:** ______________

Patient Name (Print): ______________________________ **Date of Birth:** ______________

Tallahassee Primary Care Associates, P.A.
Corporate Policy

FINANCIAL POLICY

- <u>**Payment is always due PRIOR to service:**</u> We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are actually processed by the insurer. We will of course notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- <u>**PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.**</u>
- **Our Billing Services**: We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our web site for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. PLEASE NOTE THAT TPCA IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY H.M.O. PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMENT WITH THE H.M.O. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR H.M.O.
- **Co-Pays, Deductibles, and Co-Insurances**: Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contract with your insurer, and are your part of your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
- **Secondary Insurances**: If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- **Tertiary Insurance: If applicable,** tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at the time of your appointment.
- **Charges for failing to come to your appointment (generally termed "no-show fees"):** The following fees will apply if you fail to present for an appointment:
  $25.00: - Office visits (or as determined by each office), Ambulatory Cardiovascular monitors.
  $50.00: - Ultrasound, CT, Travel Clinic (you must provide notice of cancellation to our Diagnostic Department scheduling personnel at least 24 hours prior to your scheduled appointment time).
  Variable: - Nuclear Medicine Studies (Patients failing to show for an appointment without providing at least 24 hours cancellation notice will be charged the cost of the Radioisotopes, which varies based upon market conditions. This cost has historically fluctuated in the $50-$250 range).

Tallahassee Primary Care Associates, P.A.
Corporate Policy

- **Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question, if you believe there is a mistake on your statement, or if you have any concern about your statement transactions, we expect to hear from you in a timely manner (you may contact your physician's office, but for billing questions you may be referred to our billing department, which will most likely be our best resource for your inquiry). We reserve the right to avoid the cost of sending statements to patients who have a small balance outstanding (usually less than $5.00). For small balances, our Patient Registration/Reception staff in your physician's office will collect the balance at your next appointment.
- **Financial Promissory Form:** If you are truly unable to make payment in full for your portion of financial responsibility at the time of service, you will be required to sign a Financial Promissory Agreement. In this Agreement, you will have 14 calendar days to submit payment in full. If you do not make payment within 14 calendar days, we will add an **additional $25.00 administrative fee to the original copay, deductible, and/or coinsurance that is due**.
- **Collections:** If no payment is received within our 3rd statement cycle (approximately 90 days or more from your date of service), your account is considered delinquent and may be referred to an outside collection agency. ***Referral to outside collections may damage your credit, so we strongly urge you to contact our Billing Department to work out payment arrangements so that we can avoid this step.*** We will discharge patients who have balances that are referred to an outside collection agency.
- **Payment Plans:** Subject to the following specific rules, we permit payment plans for patients who may need additional time to pay their financial responsibility in full. Patients will adhere to our payment plan policy set forth below:
  - **We will not permit payment plans for individual patient balances of less than $100.00. The minimum balance for a payment plan is $100.00**
  - **If the balance is less than $350, you must pay the balance in full within 6 months.**
  - **Balances greater than $350 must be paid in full within 12 months.**
  - **We will expect you to make minimum payments of $50 per month.**
- **We want you to understand this document and our policies and procedures, and we do not want you to be confused. If** you have any questions or concerns about our Financial Policy, procedures or fees, your physician's office manager or our billing department can help. Please ask questions if necessary before signing below.

My signature below certifies that I have read, understand and agree to the terms of this Financial Policy.

Patient Signature: ______________________________

Date: ____________________

PATIENT INFORMATION (OFFICE USE ONLY)

Patient Name: ______________________________

D.O.B. ____________________ MRN ____________________

Tallahassee Primary Care Associates, P.A.
Corporate Policy

Financial Promissory Agreement

Dear Patient:

Your insurance company requires a Copay, Co-Insurance or Deductible to be paid when you seek certain medical services. In turn, we have a contractual obligation to collect Copay, Co-Insurance or Deductible from our patients at time of service.

If a patient desires to be seen and is unable to pay their financial obligation, we are requiring those patients to sign a "Financial Promissory Agreement" and pay the required amount due to our office within fourteen (14) calendar days.

I, ______________________________, understand that my insurance company requires Copay, Co-Insurance or Deductible be paid for healthcare services provided to me, or my dependent. On this date, I desire to receive services without paying the required Copay, Co-Insurance or Deductible at the time of service.

I promise and attest that I will pay the required amount due of $ ____________to Tallahassee Primary Care Associates within fourteen (14) calendar days.

Failure to make payment in fourteen (14) calendar days will result in an **additional $25.00 administrative fee to be added to the original Copay due**.

I, also, understand that failure to make the required payment may result in collection proceedings, health insurance notification, and possible credit degradation.

***PLEASE WRITE CLEARLY**

Signature ____________________________________ Acct. # ______________

Date ______________________

Patient's name if different than signer: ________________________________

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Primary Care Associates, P.A. ("TPCA") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Primary Care Associates prior to signing this document, and I acknowledge that the TPCA Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Primary Care Associates is also available on the website for TPCA at www.TallahasseePrimaryCare.com. I understand that my physician is a part of TPCA, and that this notice applies to the protected health information that my physician, as a part of TPCA, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TPCA, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TPCA participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example www.hienetworks.com is included on page 2 of this document. The information exchanged in these activities may include my protected heath information. I hereby authorize such transmissions. I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of HIE activities directly to our Privacy Officer through email at Compliance@TallahasseePrimaryCare.com or by mailing a written request to Privacy Office at 1803 Miccosukee Commons Drive, Suite 101, Tallahassee, FL 32308.

TPCA reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at www.TallahasseePrimaryCare.com.

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TPCA of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or through an attorney-at-law.

A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE

Important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Primary Care Associates, P.A. participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

Kristin Harmon, MD
2623 Centennial Blvd, Suite 204
Tallahassee, FL 32308
850-702-5007 p
850-219-1059 f

PATIENT COMMUNICATION INSTRUCTIONS

Date of Birth: ________________

Name: ____

Address: ____

COMMUNICATION METHODS:

1. Cell Home Work Email Text ___________________________ Details No Details
2. Cell Home Work Email Text ___________________________ Details No Details
3. Cell Home Work Email Text ___________________________ Details No Details
4. Cell Home Work Email Text ___________________________ Details No Details
5. Cell Home Work Email Text ___________________________ Details No Details

**Email communication will require a Web Portal account

COMMUNICATION AUTHORIZATION:

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

EMERGENCY CONTACT INFORMATION:

Name: ____________________ Relationship: ______________ Phone: _______________

You may get a copy of our Notice of Privacy Practices at any time.

This authorization will expire on: __________
(if no date is specified, it will expire upon your completion of a new/replacement form)

____ _______________
Signature of patient or legal guardian Date

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through HIE Networks (www.hienetworks.com)

HIE Networks is engaged to deliver easier ways to communicate information and share HIPAA-compliant medical correspondence between healthcare providers. From electronic faxing to intuitive interfacing and clinical data exchange, communications are electronically streamlined to reduce errors and increase staff and patient satisfaction
Unless you specifically opt out as provided below your personal health information will be provided to organizations such as HIE Networks under secure methods with HIPAA compliant agreements. Tallahassee Primary Care Associates and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

Clinical data exchange generally includes-a group of organizations and stakeholders that exchanges data electronically in a manner that is fully HIPAA compliant technologically and controlled by HIPAA compliant agreements between the parties in order to improve the quality, safety, and efficiency of healthcare delivery.

Example information on this effort and participation-can be found at www.HIENetworks.com. Example information on HIE generally and the national efforts in that regard can be found at www.healthit.gov.

Consent for Services of a Minor Child

In almost all cases, Tallahassee Primary Care Associates (TPCA) requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services in the Diagnostic Imaging Center, Lab, Clinical Services departments and/or primary physician's offices for a minor child under the age of 18.

All parent(s) or guardian(s) are encouraged to attend all medical appointments at Tallahassee Primary Care Associates, but we understand that isn't always possible. To avoid having to reschedule appointments when a parent(s) or guardian(s) is unable to attend, this consent form authorizing TPCA and its medical professional to provide medical care must be signed by the appropriate person.

I, (We) ________________________________ and ________________________________ do hereby state that I am (we are) the parents or legal guardians of (child's name) __________________, of minor age born on ______________________.

Please Initial options below

______ (I) We authorize and consent to all professional services provided at or arranged within the primary care office and their ancillary department(s).

______ (I) We authorize and consent to any medically necessary treatment within the primary care office only and not ancillary department(s).

______ (I) We do not give consent for ______________________________(list specific test/services) services.

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND TREATMENT AUTHORIZATION

The below adults are authorized to seek medical care and/or ancillary services in place of the minor child's parent and/or legal guardian.

Name: ______________________________ Relationship to minor: ____________________

Name: ______________________________ Relationship to minor: ____________________

Name: ______________________________ Relationship to minor: ____________________

Name: ______________________________ Relationship to minor: ____________________

Consent expires on: ______________________ *(If not dated, then it will expire one year from signed date)*

Patient name: Print: ___________________________ Sign: ________________________________

Parent/legal guardian name (*if patient is of minor age*): Print: ____________________ Sign: __________________

Date: ________________________ Explain your relationship to patient: ____________________________

Tallahassee Primary Care Associates, P.A. (TPCA) does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs or activities.

TPCA Tallahassee Primary Care Associates

Our primary care is you.

TPCA Tallahassee Primary Care Associates

Our primary care is you

Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name: ____ Date of Birth: ____________________
(Last, First, Middle/Maiden)

Patient's Address:______________________________ City:________________________ State:__________ Zip:__________

Phone Numbers:________________________________

I authorize my physician and/or administrative and clinical staff at Tallahassee Primary Care Associates or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	Person or Entity to Disclose Information:
Name/Organization: Kristin Harmon, MD	Name/Organization: ______________________
Address: 2623 Centennial Blvd, Suite 204	Address: ______________________
City, State, Zip: Tallahassee, FL 32308	City, State, Zip: ______________________
Phone: 850-702-5007 Fax: 850-219-1059	Phone: ______________ Fax: ______________

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

__ Complete Medical Record
__ Lab Reports
__ Obstetrical (OB) Records
__ Billing Records
__ Surgery Records
__ Pap Smear / Biopsy Reports
__ Office Notes
__Mammogram Reports
__Other (specify): ______________________
__ Ultrasound Reports

DATES OF SERVICE: ____

PURPOSE:___ Changing Physicians ___ Personal Copy to Patient ___ Attorney ___ Insurance___ Workers' Compensation

Other ____

This authorization will expire on: ____________________(If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

___ I DO___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV infection** (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.
Initials of individual giving authorization: __________

___ I DO___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions.**
Initials of individual giving authorization: __________

___ I DO__ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related and/or alcohol-related treatment.**
Initials of individual giving authorization. __________

I have read and understand the nature of this authorization and I have been provided a copy of TPCA's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at ***Tallahassee Primary Care Associates, P.A., Administrative Offices 1803 Miccosukee Commons Drive, Tallahassee, Florida 32308, Attn: Compliance Officer or email Compliance@TallahasseePrimaryCare.com.*** I understand that a revocation is not effective to the extent that my physician or Tallahassee Primary Care Associates has taken action in reliance upon this 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. I also understand that such revocation does not affect TPCA's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

______________________________ ______________________________
Signature of Patient or Patient's Representative Witness

______________________________ ______________________________
Relationship to Patient Date
(If applicable, attach document of guardianship or Power of Attorney)

FEE FOR COPIES - Tallahassee Primary Care Associates follows applicable Federal Law for copying charges as outlined in the Code of Federal Regulations Section 164.524.