Serenity Women's Care

Patient Information Record

Please Print

Patient Name _____ Age _____ Gender ☐M ☐F
Last First Middle Initial

Home Phone ___-___-___ Cell Phone ___-___-___ DOB ___/___/___ SSN ___-___-___

Email Address _____ Preferred method of contact _____

Phone Number to leave confidential information:_____

Marital Status _____ Race _____ Ethnicity _____ Language _____

Street Address _____
City State Zip

Employer _____ Occupation _____ How Long _____

Employer Address _____ Phone ___-___-___
City State Zip

Primary Doctor _____ Phone ___-___-___

Primary Doctor Address _____
City State Zip

Pharmacy _____ Cross Streets _____ Phone ___-___-___

Referred by: Google Yelp Other Provider Current Patient

Emergency Contact _____ Relationship _____

Street Address _____ Phone ___-___-___
City State Zip

Primary Insurance Company _____ **ID#** _____

Policy# _____ Group#_____ Policyholder's Name _____

Relationship to Patient _____ DOB ___/___/___ Policyholder's Social Security Number ___-___-___

Policyholder's Employer _____

Other Insurance Company _____ **ID#** _____

Policy# _____ Group#_____ Policyholder's Name _____

Relationship to Patient _____ DOB ___/___/___ Policyholder's Social Security Number ___-___-___

Policyholder's Employer _____

I CONFIRM THAT THE INFORMATION I HAVE PROVIDED IS CORRECT TO THE BESTOF MY KNOWLEDGE

_____ _____

Responsible Party Signature: Date:

Serenity Women's Care Confidential Medical History

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Allergies to

Medications/food/environment	Reaction	Severity	Reaction	Onset
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood
_____		Very Mild/Mild/Moderate/Severe	_____	Adulthood/Childhood

Current medications

Name of prescription, over the counter and herbal Reason Used	Prescribing Doctor	Dose	Instructions
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History : Please complete if any of your close relatives have had any of the following:

Disease	Circle	Family Member	Paternal/Maternal	Age of onset	Age of Death	Cause of Death
Cancer of Breast	Y N	_____	_____	_____	_____	Y N
Cancer of Ovary	Y N	_____	_____	_____	_____	Y N
Cancer of Uterus	Y N	_____	_____	_____	_____	Y N
Cancer of Cervix	Y N	_____	_____	_____	_____	Y N
Cancer of Colon	Y N	_____	_____	_____	_____	Y N
Diabetes	Y N	_____	_____	_____	_____	Y N
Tuberculosis (TB)	Y N	_____	_____	_____	_____	Y N
Heart Disease	Y N	_____	_____	_____	_____	Y N
High Blood Pressure	Y N	_____	_____	_____	_____	Y N
Other	Y N	_____	_____	_____	_____	Y N

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

What do you do so you don't become pregnant?

_____ Diaphragm _____Condoms _____Sponge _____ Rhythm _____ IUD
_____ Withdrawal _____ Depo Provera _____ Vasectomy _____ Nexplanon _____Pills

_____Essure _____Tubal Ligation _____ Implanon/Nexplanon _____Ortho Evra _____Nuva Ring

Other_____

First day of your last period ____/_____/_____ What age were you when you started your first period? _____

Are your periods regular? Y N Is there bleeding between periods? Y N How often do your cycles occur? _____

For how many days do you bleed? _____

Flow is: ____ Scant ____Mild ____ Mod ____Severe ____ Incapacitating

Other symptoms with periods?
_____

Date of last pap smear ____/_____/_____ Have you had an abnormal pap smear? Y N Has this been treated? Y N

How?
_____

Do you examine your breasts regularly? Y N When was the last Mammogram (if any)? ____/_____/_____

Results _____

Do you have concerns about your breasts?
_____

When was your last Bone density test (if any)? ____/_____/_____

Results _____

Have you had:

Pain with intercourse? Y N Explain:_____

Bleeding with intercourse? Y N Explain:_____

Concerns about vaginal discharge? Y N Explain_____

Leaking of urine? Y N Explain:_____

Pelvic infections? Y N Explain:_____

Sexually transmitted diseases? Y N Explain:_____

Medical Condition Past medical (include injuries and conditions requiring medication i.e.- High blood pressure, seizures etc.)

Condition	Date	Treatment
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Total number of pregnancies:

Full term _____ Premature _____ Cesarean section _____ Vaginal delivery _____ Ectopic _____

Miscarriage_____ Abortion _____ Stillborn _____ Live at birth _____ Live at present _____

Pregnancy History:

Preg#	Sex	Month/Year	# of weeks	Weight	Hrs of labor	Delivery type	Delivery Doctor	Obstetrical/Neonatal problems
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____
_____	_____	_____/_____	_____	_____	_____	_____	_____	_____

Social History

Do you smoke currently? Y N Did you previously some? Y N

If yes, type of tobacco? _____Number of years? _____Packs per day? _____

How long ago did you quit? _____

Do you drink alcohol? Y N If yes, type of alcohol_____ How often? _____

Amount? _____ Last drink? _____/_____/_____

Do you consume caffeine? Y N If yes, what kind? _____ Amount? _____

Do you use recreational drugs? Y N If yes, what kind? _____ Amount? _____

Do you exercise (frequency)? ____ Daily ____ Occasional ____ 2-3 times a week ____ 4+/week ____ Never

How many sexual partners have you had? _____ Less than 5 _____More than 5

Sexual partner gender? ___ Men Only ____Women Only ____ Both

Have you been exposed to sexual or physical violence or abuse? Y N

If medically necessary, would you agree to a transfusion? Y N

Highest level of education? _____

Current Occupation?_____

Living Situation? _____ Live Alone _____ With Spouse/Significant Other _____ With Family

Marital Status? _____

Surgical History:

Surgery	Date	Reason
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____
_____	____/_____/_____	_____

Date ____/_____/_____

Name_____ Birthdate____/_____/_____ Age _____

Review of Systems

If you are experiencing any of the symptoms listed, PLEASE **CIRCLE** THE ONES THAT APPLY, or write **NONE.**

Constitutional (Health in General): Fatigue, Fever, Night sweats

Ears, Nose, Mouth and Throat: Eye discharge, Vision loss, Ear drainage, Hearing loss, Nasal drainage

Respiratory: Cough, Wheezing, Difficulty breathing or Shortness of breath

Cardiovascular: Chest pain, Irregular heartbeat, Palpitations

Gastrointestinal: Abdominal Pain, Constipation, Diarrhea, Vomiting

Dermatologic: Skin itching, Rash

Muscoloskeletal: Bone weakness, Joint weakness

Hematology: Easy bleeding, Easy brusing

Immunology: Environmental allergies, Food Allergies

Serenity
WOMEN'S CARE

10615 N. Hayden Rd. C100 Scottsdale AZ 85260

Phone: 480-825-7941 Fax: 480-825-7945

Payment Policy (Non-Medicare)(Non-Self Pay)

We are committed to providing top quality care to our patients at reasonable prices. Patients who do not pay for care drive up costs for those who do. We believe this is unfair. Therefore, we require that all patients adhere to the following strict payment policy.
All patients are required to pay any co-payment amount and all past due balances at each check in. In addition, at each visit, all patients are required to either: Present a valid insurance card - OR - Pay for services prior to receiving services.
Once an account is turned over to a collection agency, we incur significant additional costs and we will not be able to work with you on payment arrangements. Furthermore, we will not be able continue seeing you as a patient if you do not pay your balance.
Patients are responsible for all charges indicated as patient responsibility by their insurance companies. Patients are solely responsible for knowing their coverage limitations and their financial responsibility *before* accepting diagnosis or treatment.

Patients are responsible for charges stemming from companies who provide lab work, imaging, anesthesia, cord blood collection, surgical assistance or other tests or services related to their care. Patients are responsible for all charges they incur by these companies, and we have no influence over their billing practices, even though some services are performed within our offices for your convenience. Patients who receive diagnosis or treatment in our office accept responsibility for all charges which may result from leaving samples of urine, saliva, blood, or other tissues collected by a provider (e.g. biopsy). We will not pay the bill you may receive from these companies for services they perform in conjunction with your care. It is your responsibility to be informed before you leave a sample or consent to any diagnosis or treatment our providers may provide.
Patients having a positive patient account balance will receive monthly statements. If no payment is received within ninety days from your date of service, patient's account will be turned over to a collection agency and subject to late fees or interest. A patient's credit rating will be impacted. Any returned payments will be accessed a $35.00 return fee and will not be able to schedule any new appointments until balance is paid in full.
I, the undersigned, hereby acknowledge that I have read and agree with the above payment policy. I understand and agree that I am responsible for all charges deemed my responsibility and I authorize Serenity Women's Care, to take the above actions to collect payment. I agree that I am responsible for any late fees, interest fees, collection fees, or legal fees related to collecting payment for my charges. I further authorize Serenity Women's Care, to report me to a collection agency or to credit agencies, if required. I understand that Serenity Women's Care, submits insurance claims on my behalf, if applicable, but that I am ultimately responsible for payment of all charges.

I authorize Serenity Women's Care to bill the insurance company for any services rendered. I authorize payments of medical benefits to the provider for services, rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim.
Signed _____ Dated _____

Patient Name _____ Date of Birth _____

JeanAnn Schwark, M.S., F.N.P.-C

10615 N. Hayden Rd. C100 Scottsdale AZ 85260

Phone 480-825-7941 Fax 480-825-7945

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows", and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize the needs of all of our patients.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call Serenity Women's Care promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. **Any cancellations without a 24-hour notice will be charged $50, and if you were scheduled for a procedure you will be charged $75.** Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call (480) 825-7941. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.
Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice.

No Show Policy

A "no-show" is someone who misses an appointment without calling ahead to cancel. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show".

- Any missed appointment there will be a $50.00 fee billed to your account. If you were scheduled for a procedure there will be a $75.00 fee billed to your account.

Phone Consultations

For some patients, in certain selected situations a telephone consultation is more convenient. As a courtesy, we are happy to schedule a telephone consultation. The fee is $75.00, and this is not billable to insurance.

Signature_____ Date _____

10615 North Hayden Road, Suite 100 Scottsdale, AZ 85260

Phone 480-825-7941 Fax 480-825-7945

NOTICE OF PRIVACY POLICIES AND PRACTICES

THIS NOTICE DESCRIBES HOW SERENITY WOMEN'S CARE. MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. SERENITY WOMEN'S CARE is required by law to maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.
Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
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. We also may release Health Information to funeral directors as necessary for their duties.
National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.
Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:
1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to records Serenity Women's Care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to records Serenity Women's Care.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to records Serenity Women's Care.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to records Serenity Women's Care. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

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 by mail or at work. To request confidential communications, you must make your request, in writing, to records Serenity Women's Care. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

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 this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our office at 8070 E Morgan Trl, Ste 120 Scottsdale, AZ 85258. To obtain a paper copy of this notice please request one from a receptionist.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. Copies of our current notice are available at any of our offices. The notice will contain the effective date on the last page, in the bottom right-hand corner.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Department of Health and Human Services at our office. To file a complaint with our office, contact our Practice Administrator at 480-825-7941. All complaints must be made in writing. You will not be penalized for filing a complaint.

Revised and Effective 06/2018

AUTHORIZATION TO RELEASE INFORMATION (:

I voluntarily authorize Serenity Women's Care to use or disclose the protected health information as indicated below to the individual (i.e. spouse, parent) given below:

Name:_____

Phone:_____

- o **I authorize the release of my complete health record (including records relating to mental healthcare, communicable disease, HIV or AIDS, and treatment of alcohol or drug abuse).**
- o **I authorize the release of my complete health record with the exception of the following information: please specify:**_____

I have received and reviewed a copy of the privacy policies and information.

Patient Signature _____ Date_____

Revised and Effective 06/2018

JeanAnn Schwark, M.S., FNP-C

10615 N Hayden Rd. C100 Scottsdale, AZ 85260

Phone 480-825-7941 Fax 480-825-7945

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records between

Serenity Women's Care

10615 N Hayden Rd. C100 Scottsdale, AZ 85260

and (name and address of the health care provider):

Name of Office/Provider_____

Address/Phone Number_____

I am releasing records (Check only one) __ **TO Serenity Women's Care**

__ **FROM Serenity Women's Care**

Place a check mark below to indicate the records you wish to release:

___ All Records (last 2 years) ___ Lab Reports(last 2 years) ___ Pap(last 2 years)
___ Ultrasounds(last 2 years) __ Doctor's Notes(last 2 years) ___ Other (last 2 years)
_____

Reason for release (please be as specific as possible):

_____

_____

I understand that I may revoke this consent at any time and that, upon fulfillment of the above stated purpose this consent will expire one year following the date of signature.

Patient Name _____ D.O.B_____/_____/_____

Signature _____ Date_____/_____/_____