MAB
MEDICAL ASSOCIATES OF BREVARD

Patient Information

Patient Name

First MI Last

DOB ___/___/_____ SS# _____

Marital Status_____ ○ MALE ○ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

○ Check if same as patient's address

Race
○ American Indian or Alaska Native ○ Asian
○ Native Hawaiian ○ Black or African American ○ White
○ Other Pacific Islander ○ Prefer not to answer

Ethnicity
○ Hispanic/Latino ○ Non-Hispanic/Latino
○ Prefer not to answer

Preferred Language
○ English ○ Spanish ○ French ○ Indian (includes Hindu & Tamil) ○ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/_____ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/_____ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

Patient Name _____

Financial Policy

I, _____,
understand that I am financially responsible for all charges for services to me, including co-payments, co-insurance, out-of-pocket, deductibles and noncovered services. I authorize the payments from my insurance company(s) according to my medical benefits be made payable to Medical Associates of Brevard for professional services rendered. I understand that I will receive statements, reflecting my account balance and that the FINAL PAYMENT of this account is my responsibility. Furthermore, should I default on payment for services rendered I agree to pay all collection costs including reasonable attorney's fee. I authorize the disclosure of my medical information to all of Medical Associates of Brevard as well as to my insurance company(s).

LIFETIME SIGNATURE AUTHORIZATION: This signature and assignment is to be a continuing one, remaining in effect until revoked in writing by the undersigned. It signifies that all information given is current.

_____
Print Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

HIPAA Release

I authorize Medical Associates of Brevard to discuss my healthcare information with:

Name	Relationship	Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification. I authorize Medical Associates of Brevard to leave a detailed message on my answering machine / voicemail and/or with the person(s) authorized above:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Notice of Privacy Practices & Consent to Obtain External Prescription History

Initial below

_____I acknowledge that I have received a copy of the **Provider Notice of Privacy Practices** for Medical Associates of Brevard. The Provider Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Provider Notice of Privacy Practices also describes my right and the responsibilities of duties of Medical Associates of Brevard with respect to my protected health information.

_____ I declined the Notice of Privacy Practices

Consent to Obtain External Prescription History

_____I authorize Medical Associates of Brevard and its physicians and staff to view my external prescription history via the electronic medical records system Medent, and the Surescripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

Print Name of Patient or Personal Representative	Signature of Patient or Personal Representative	Date

ADVANCED DIRECTIVE

MD VIP – MARK F. PINSKY D.O

All adults in health care settings have the right in the state of Florida to an *"Advanced Directive"*. This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An *Advanced Directive* enables you to state your choice or may name someone to make your choice for you if you should be come unable to make decisions about your medical treatment. An advanced directive can enable you to make decisions about your future medical care.

I have received information on *"Advanced Directive."*

Signature:_____ Date:_____

ADVANCED DIRECTIVES

(for compliance with the patient self-determination act)

Have you executed an *Advanced Directive*? Yes_____ No_____

If yes, is this directive in the form of:

_____ Living will

_____ Durable Power of Attorney

_____ Health Care Surrogate

If you have executed an *Advanced Directive* in any of the above formats, have you provided this office with a copy for your medical records?

_____ Yes _____No

_____

Patient Name (Please print) _____ **DOB:** _____

PAST MEDICAL HISTORY: Please check if you or have you ever had:

✓	DISEASE	COMMENTS
	Seizure Disease?	How often? _____
	Thyroid Disease	____Hypothyroidism_____Hyperthyroidism _____Goiter
	Pulmonary Disease	____Asthma_____COPD _____Emphysema_____TB_____Pneumonia
	Stroke	___TIA (mini stroke)____Sudden blindness ___Weakness in arm s/legs ____Carotid stenosis_____Bruit
	GI Disease	____Ulcers ____Hiatal Hernia ___GERD ____Diverticulitis ____Crohn's ____Gallstones
	Diabetes	____Insulin dependent ___Non-insulin ___Controlled by diet
	Kidney Disease	____ESRD ____Dialysis
	Blood Disease	____Bleeding Disorder____Clotting Disorder
	Liver Disease	____Hepatitis___Cirrhosis
	Cancer	____Type:
	Vascular Disease	__Peripheral Vascular Disease___Angioplasty/Stent____Leg/Foot Ulceration __ Claudication ___Decreased walking distance_Foot pain at rest ___ Foot pain during exercise____Extreme discoloration changes __ Loss of limb____Aneurysm ___Diabetic neuropathy____Temperature changes
	Heart Disease	___Heart Attack/ MI_____Angina Hypertension_____CHF __Coronary angioplasty/stent/PTCA____Open heart surgery/CABG. __AFIB_____IRRG HR____Murmur____Rheumatic heart disease ___ Valve disease/repair/replacement ___Coronary heart disease

MEDICATIONS: List **ALL** medications, including the dosage. Please include all over-the-counter medications, vitamins, herbs, etc.

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES: List **ALL** medicine and foods, include the reaction you get.

_____

_____

_____

_____

Patient Name (Please print) _____ DOB: _____

PREVIOUS SURGERIES: Please include the dates.

_____

_____

_____

_____

_____

PREVIOUS HOSPITALIZATIONS: Please include the dates.

_____

_____

_____

_____

FAMILY HISTORY:

Check any condition that any BLOOD relative has/had and state whom:

_____DIABETES _____

_____HYPERTENSION _____

_____HEART DISEASE _____

_____STROKE _____

_____MENTAL ILLNESS _____

_____CANCER _____

_____EPILEPSY _____

_____HIGH CHOLESTEROL _____

_____OBESITY _____

_____OTHER _____

FAMILY HISTORY

	Alive	Deceased	Age	Health	If deceased, cause of death
Father					
Mother					
Siblings					
Children					
Grandparents					

MALE PATIENTS

Have you had any of the following: (circle all that apply)
Penile discharge/sores
Testicular pain or masses
Change in libido Sexual difficulty
Circumcision Venereal disease

Patient Name (Please print) _____ DOB: _____

FEMALE PATIENTS

Have you had any of the following: (circle all that apply)

Abnormal menstrual cycles
Bleeding between menstrual cycles
Absence of menstrual cycles Vaginal discharge/sores
Change in libido
Venereal disease
At what age did you begin menstruation? _____
What is the usual length of your period? _____ days.
What method of contraception do you use, if any? _____
What age did you reach menopause, if applicable? _____
When was your last pap smear? _____
What were the results of your last pap smear? _____
Do you perform monthly breast self-examinations? □Yes □No
Have you noticed any pain, discharge, masses, dimpling, or nipple changes in your breast?

SLEEP HISTORY

Do you have any of the following: (circle all that apply)

Snoring
Trouble falling asleep
Trouble staying asleep
None of the above

PREVIOUS TESTS: Please include dates

_____ Colonoscopy
_____ Endoscopy/EGD
_____ Sigmoidoscopy
_____ Prostate Exam &/or PSA
_____Hemoccult cards (to check for blood in stool)
_____Eye Exam
_____DEXA scan
_____Mammogram (female patients)
_____Stress Test

PREVIOUS VACCINES: please include dates

_____ Flu Vaccine
_____ Prevnar 13
_____ Pneumovax 23
_____ Shingles vaccine
_____TDAP

Patient Name (Please print) _____ DOB: _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: Circle One: Married Widowed Divorced Single

Children: How Many? _____ Ages: _____

Do you exercise? _____ No _____ 1-3 days/week _____ more than 3 days/week

_____Walk _____Run _____Bike _____Gym Other_____

Do you or have you ever smoked? No Yes
If yes please answer the following.

Current Smoker _____ Former Smoker _____

_____Cigarettes _____Pipe _____Cigars _____Chew

_____Packs per day How many years _____

If you quit how long has it been since you last smoked? _____

Do you or have you ever consumed alcohol?

_____No _____Yes If yes, how many years? _____

How many drinks per day? _____
How many drinks per weekend? _____
What types of alcohol do you usually drink? _____

Do you have any pets? _____ If yes, what type? _____

What is your daily caffeine intake? (per cup – state amount)

Coffee _____ Tea _____ Soda _____ Cocoa Chocolate _____

Do you currently have any nutritional concerns? _____ YES _____NO If yes what are they?

_____

_____

In case of a surgical emergency, are you willing to receive blood or blood products? YES NO

SYMPTOM	NO	YES
EYES		
Change in Vision		
Double Vision		
EARS		
Ringing/buzzing in ears		
Hearing difficulties		
MOUTH		
Dry mouth		
Bleeding gums		
Dental Problems		
NOSE		
Nose bleeds		
Frequent congestion		
Post nasal drip		
HEAD		
Frequent headaches		
Painful sinuses		
NECK		
Neck Pain		
Neck Stiffness		
Neck Lumps or swelling		
THROAT		
Hoarse voice		
Difficulty swallowing		
LUNGS		
Wheezing		
Shortness of breath		
Coughing up blood		
Coughing up Sputum		
Pain when breathing		
History of Tuberculosis		
CARDIAC		
Attacks of racing heart beat		
Chest pain or heaviness		
Dizzy spells		
Swollen feet or ankles		
Leg cramps when walking		
History of heart murmur		
Shortness of breath		
Difficulty sleeping		
DIGESTIVE		
Irritable Bowel Syndrome		
Heartburn		
Vomiting		
Stomach pains		
Diarrhea		
Black stools		
Constipation		

SYMPTOM	NO	YES
DIGESTIVE CONTINUED		
Yellow jaundice		
Vomiting Blood		
Chrons Disease		
UROLOGIC/URINARY		
Frequent urination		
Getting up at night to urinate		
Wetting pants on coughing		
Burning with urination		
History of kidney stones		
History of urinary tract infections		
Urinary incontinence		
Blood in urine		
MUSCULOSKELETAL		
Painful or stiff joints		
Swollen Joints		
Back Pain		
Muscle aches		
SKIN		
Brusing easily		
Skin Cancer		
Itching/Redness/Rash/Blisters		
PSYCHOLOGIC		
Depression		
Anxiety		
Insomnia		
NEUROLOGICAL		
Fainting spells		
Lightheadedness		
Seizures		
Convulsing		
Tremors		
Confusion		
History of Stroke		
Change in thoughts		
Vertigo		
Sudden loss of vision		
Loss of memory		
Disoriented		
GENERAL		
Wight gain		
Weight loss		
Loss of appetite		
Night sweats		
Fatigue		
Fevers		
Shaking chills		
Excessive thirst		

Dr. Mark F. Pinsky, D.O
8045 Spyglass Hill Road Suite 101
Melbourne, FL 32940

Phone: (321) 255-2289
Fax: (321) 241-6583

CONTROLLED SUBSTANCE/ PAIN MEDICATION AGREEMENT AND CONSENT

1. The purpose of this Agreement is to ensure that I, _____, fully understand the risks and benefits of using controlled substances to manage my medical condition or disease. Treating my pain is a collaborative process that depends on the trust, honesty and confidence I share with Dr. Mark F. Pinsky. The success of this Agreement, and my treatment more generally, rests upon my willingness to communicate with Mark F. Pinsky and follow his recommendations. This Agreement will provide me with a blueprint to build such a relationship.

TREATMENT GOALS

The goal of treatment is to manage my conditions so that I can live a more productive and active life. Dr. Mark F. Pinsky and I have talked about how my condition affects me and how the prescribed controlled substance/s may manage my condition. Together, we agreed to work towards the following goals:

_____

_____

_____

_____

_____

1. Dr. Mark Pinsky explained that my treatment plan has been specifically tailored to my needs. I understand that compliance with my plan is necessary to meet my treatment goals.

2. I understand that as part of this plan I will be expected to follow better health habits and Dr. Mark Pinsky recommends [increases in activity and exercise, weight control, avoidance of tobacco and alcohol, and participation in functionally restorative programs including physical/occupational therapy and/or other psychological counseling].

3. Even if I follow my treatment plan, I understand that there is no guarantee that my treatment will be effective and Dr. Mark Pinsky explained that treatment may not completely eliminate my symptoms. I understand that the goal of my treatment is to improve or decrease my symptoms and may not remove them entirely.

4. I understand that my treatment may require the prolonged or continuous use of controlled substances, but I recognize that the ultimate goal of my therapy is to effectively manage my symptoms without these medications if possible.

PATIENT INFORMED CONSENT

1. I understand that the prescription of controlled substances will begin as a trial and continue only if there is evidence of benefit. If I do not make observable progress towards my treatment goals, I understand that Dr. Mark Pinsky will discontinue my controlled substance therapy.

2. I have discussed with Dr. Mark Pinsky alternate methods of symptom management that do not involve controlled substances, including their risks and benefits. We decided together that controlled substances, in combination with some of these therapies discussed, if applicable, will best manage my symptoms.

3. Dr. Mark Pinsky explained, and I understand, the common side effects of my chosen course of therapy, including adverse side effects that I may experience. I understand that overuse of (taking too much of my medication or taking more than indicated by Dr. Mark Pinsky) or abuse of all and any controlled substances can decrease respiration (breathing), which may lead to death.

4. I understand that prolonged or continuous use of controlled substances may lead to addiction, physical dependence, tolerance and withdrawal. I understand that history of drug abuse, alcohol use, and mental health history can increase the risk of addiction, tolerance and physical dependence.

5. I understand that the use of controlled substances has increased potential risks that include but are not limited to: Constipation or urinary retention, interference with physical and/or mental functioning, respiratory depression, decreased appetite/nausea/vomiting/itching.

6. Narcotics and controlled substances may interfere with driving, operating machinery or other requirements of my job. I understand that it is my responsibility to avoid these risks.

7. I understand that abrupt discontinuation of a narcotic drug may cause nausea, vomiting and sweating or trigger withdrawal syndrome. I understand that stopping these types of medications can cause me to miss or crave it.

8. I understand that in the future, controlled substances may not work to manage my symptoms. It will be necessary to slowly taper from the controlled substance medication and develop other behaviors for symptom management and/or control (e.g., healthy diet, exercise, stress management, etc.).

9. Pregnancy Risk- I understand that controlled substances can affect a developing fetus and may result in birth defects. I agree to inform my doctor if I am currently pregnant, plan to become pregnant or should become pregnant during the course of treatment.

10. Opioids as well as some other controlled substances have also been known to cause decreased sexual function and libido. This is due to their effects on suppression of certain hormones such as testosterone and DHEA which can cause these side effects.

PATIENT RESPONSIBILITIES

I will fully, accurately and honestly communicate the following to Dr. Mark Pinsky to allow for the adjustment or assessment of my treatment plan:

- The nature and intensity of my symptoms
- Current and past treatments for my symptoms
- Underlying or co-existing diseases and/or conditions
- The effect of my symptoms on my physical and psychological function and quality of life
- How treatment has affected my symptoms
- Any and all prescription medications I am currently taking or begin to take
- Any medications prescribed by other physicians
- My or my family's psychiatric, addiction and substance abuse history
- Any side effects I experience as a result of my therapy

PATIENT AGREEMENT

1. I will follow my treatment plan, take my medication only as Dr. Mark Pinsky recommends, and ask questions if I do not understand his/her directions. Dr. Mark Pinsky and I will work together to change my treatment plan if the current plan is not meeting our goals.

2. I understand that Dr. Mark Pinsky will need to monitor my therapy to ensure that I am taking my medications properly and safely. As a result, I will:

    - Allow Dr. Pinsky to count the number of my pain medication pills to determine if I am taking my medication correctly.
    - Undergo a drug test, within 24 hours of upon Dr. Pinskys request, to determine if I am taking my medication correctly and to verify that I am not taking any other prescription medications that I am not prescribed by Dr. Pinsky other than those medications I previously disclosed to Dr. Pinsky or illicit or recreational drugs.
    - Immediately notify Dr. Pinsky upon receiving, and prior to taking, any medications prescribed by a provider that is not Dr. Pinsky.
    - I give my full consent for Dr. Mark Pinsky and Medical Associates of Brevard to check the state Prescription Drug Monitoring Database in this and all participating states to ensure that I am filling my prescriptions properly and not receiving other controlled substance prescription medications from any other source.
    - I understand that I am required to have drug test performed regularly and randomly without notice.
    - I will only seek to obtain prescriptions for treatment of my symptoms or any controlled substance from Dr. Mark Pinsky. I agree not to take controlled substances from any other source.

- I understand that prescriptions for pain medication or refills for those medications will only be made as determined by my treatment plan. I understand that each prescription I receive will last me to my next scheduled refill.
- I understand that refills of my medication will not be made if I run out of medication before my medication is due to be refilled. It is my responsibility to take my medication in the dose prescribed according to the schedule Dr. Mark Pinsky and I establish.
- I will see Dr. Mark Pinsky, at a minimum, every ninety days. I will keep all appointments I make with Dr. Mark Pinsky. I understand that if I am not seen every 90 days or as requested by Dr. Pinsky, Dr. Pinsky will not refill my medications and I can have adverse outcomes such as withdrawal symptoms or even death.
- I understand that Dr. Mark Pinsky may need to refer me to a pain management specialist, physical therapist, psychologist or other expert as part of my care. I will make and keep all appointments with these providers, as applicable.
- Dr. Pinsky will regularly evaluate me for opioid use disorder or signs of addiction. I will comply with Dr. Pinskys recommendations regarding evaluation and treatment.
- I will not participate in any activity that may be dangerous as a result of my slowed reflexes or reaction time, such as driving a car, while under the influence of my pain medication until I know how my treatment will affect me.
- I will not use any illegal or recreational drugs; take any medication that is not prescribed to me including over-the-counter medications; or drink alcohol. Use of alcohol and other substances in combination with certain controlled substances can lead to adverse outcomes such as coma, organ damage and even death. Taking these medications or substances without Dr. Pinskys approval may reduce the effectiveness of my therapy, increase the side-effects of my medication, or cause a dangerous, and sometimes life threatening, drug interaction.
- I will not share, sell, or otherwise permit any person to access or use my medications. Therefore, I will protect my medications from theft or loss by following the recommendations of Dr. Pinsky regarding the proper storage and disposal of my medications.
- I will use only one pharmacy to fill the prescriptions I receive from Dr. Mark Pinsky and any other healthcare providers. I will immediately notify Dr. Pinsky if I switch pharmacies, or because of extenuating circumstances, I must fill a prescription at another pharmacy.
- I agree to allow Dr. Pinsky to communicate with any health care professional, family member, pharmacy, legal authority, or regulatory authority to obtain information about my care, actions or prescription history.
- I will notify any healthcare provider that treats me of this Agreement. I will explain that I am currently participating in a symptom management program, list the medications I am currently taking, and ask that provider to contact Dr. Pinsky prior to prescribing me any additional medications.
- I will comply with Dr. Pinskys discontinuance plan if my medications are ineffective at treating my symptoms, or if my treatment must be discontinued for any other reason.
- I will not be involved in the sale, illegal possession, diversion or transportation of controlled substances. I agree to participate in a program for chemical dependency should a problem be identified.
- I understand that no prescriptions will be processed on Friday and that the office requires 24-hour notice minimum for processing refills.

- The use of cigarettes demonstrates a dependence of nicotine. This complicates opioid therapy. If you have chosen to consent to treatment with opioids and are a smoker, you must agree to a smoking cessation program.

TERMINATION OF THIS AGREEMENT

Dr. Pinsky may terminate this Agreement and discontinue my treatment in this pain management program if I fail to comply with any of the requirements of this Agreement.

Circumstances that may lead to the termination of this Agreement include, but are not limited to:

- If any drug screen indicates, or Dr. Pinsky reasonably believes, that I have not taken my medication in accordance with my treatment plan.

- If any drug screen indicates, or Dr. Pinsky reasonably believes, that I have taken medication or any other prescription medications without informing Dr. Pinsky or have taken any illicit or recreational drug.

- My repeated failure to keep appointments with Dr. Pinsky or medical providers Dr. Pinsky refers me to.

- There is clinical evidence that I am no longer receiving a reasonable benefit from my medication, or Dr. Pinsky determines that I am no longer a good candidate to continue my medications.

- Dr. Pinsky reasonably believes that I have given, sold or otherwise used my drugs in a manner inconsistent with my treatment plan or this Agreement.

Prior to terminating this Agreement, Dr. Pinsky will provide me with 30 days prior written notice of his intention to discontinue my therapy. During this time, I will be given a chance to explain why this Agreement should not be terminated. I understand that Dr. Pinsky is under no duty to continuing treating me if I violate this Agreement.

In the case of termination, Dr. Pinsky will provide me with my medication for that 30-Day period. Dr. Pinsky will provide PCP or Pain Management recommendations including the recommendation of a drug-dependence treatment program, if necessary.

I _____ hereby consent to the use of narcotic/controlled medications prescribed as a means of achieving symptom control of my pain or other medical condition or disease for which these medications are intended for and or high level of daily functioning. I agree to open, honest and regular communication with my doctor to monitor my use of controlled substances.

I also am aware and consent to Medical Associates of Brevard and or Dr. Pinsky's office to pull my records from Florida's prescription Monitoring Program and all participating states, to see the list of all controlled substances or narcotics that have been filled within the last 12 months and going forward. This monitoring will be conducted regularly.

I have read this Agreement in its entirety and fully understand this agreement. All questions have been answered by the staff and/or physician. Satisfactory answers have been provided to all questions I have with regards to my treatment and this Agreement. I understand everything contained in this Agreement, including the consequences of failing to follow this Agreement, and consent to its terms.

I hereby give my consent freely, voluntarily and without reservation.

Patient Name: *(please print)*

_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

WARNING

Fraudulently obtaining or attempting to obtain a controlled substance by concealment of a material fact or failing to comply can result in felony charges or fines of at least $10,000 according to the committee of health regulation. Controlled substances can only be prescribed by one physician during the same time period.

Driving while taking opioids for chronic pain is considered medically acceptable as long as you do not have side effects such as sedation or altered mental status. Please be aware, it is possible that you could be considered DUI if stopped by law enforcement while driving.

For patients taking METHADONE:

Methadone has significant interactions with many other medications. Some of these medications may reduce your body's ability to metabolize methadone, thus INCREASING the methadone in your body, which could be dangerous. Therefore, you MUST notify this office of ALL medications prescribed for any condition while taking methadone

By signing below, you acknowledge the above warnings.

Patient Name: (please print)

_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Dr. Mark Pinsky, D.O
Medical Associates of Brevard, LLC
8045 Spyglass Hill Road. Suite 101
Melbourne, FL 32940
Phone: 321-255-2289 Fax: 321-241-6583

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____Social Security Number _____

Telephone Number _____

Reason for Release _____

Facility/ Physician records are being requested from:

_____

_____

_____

_____

Release records to: Pinsky Family and Sports Medicine Center
8045 Spyglass Hill Road Suite 101
Melbourne, FL 32940

I hereby authorize the release of information, including diagnosis and medical, surgical, laboratory, or radiological records of any and all treatment, examination, or test rendered to me during the period from _____ to_____, to include any Federal and State protected information under Florida Statute 394456 (9) Psychiatric information, Florida Statute 381.609 (2) Human Immunodeficiency Virus test results (AIDS and related conditions).

I understand and direct that this authorization will remain in effect for six (6) months or until I revoke it in writing. I hereby release the originating office or facility and its employees from any and all liability that may rise from the release of this information as I have directed. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Signature of Patient or empowered representative:

_____ Date _____

Witness Signature: _____