INTERNAL MEDICINE & HEALTHY LIFESTYLE

Location :7125 Hoffner Ave, Ste #102 , Orlando FL, 32822
Phone : 407-203-1880
Email: ramosmd@internalmedhl.com

Patient Name:
Date of Birth :

I. Acknowledge of Practice's HIPAA Privacy Note:
<u>This Authorization will expire one year from the date signed below.</u>

I acknowledge that Internal Medicine & Healthy Lifestyle has provided me a copy of the HIPAA Privacy Note and that I understand my rights and I have agreed to its terms.

- ❑ I Agree
- ❑ I do not Agree

II. Designation of Caregivers as my personal representative:

I give permission for the following person(s) to pick up prescriptions , schedule and receive any of my personal health information on my behalf. I understand that no prescriptions or health information will be released other than to the person(s) listed below.

- ➔ Person's listed below will be required to present a driver's license or other state/federally issued photo ID when picking up prescriptions,billing information and / or any personal health information.

Name :	
Relationship:	Phone number:
Name:	
Relationship:	Phone number:
Name :	
Relationship:	Phone number:

- ❑ I Agree
- ❑ I do not Agree

III. Messages :

- ➔ Please call me : Home Phone :_____ Cell Phone: _____

If unable to reach me:

- ❑ You may leave a detailed message
- ❑ Please leave a message asking me to return your call
- ❑ Do NOT Leave message on my phone mailbox

The best time to reach is (day of week)_____ Between (time)_____

IV. Email Messages:

- ❑ Use my email address to send messages for me to contact the office for information, or
- ❑ Use my email to leave detailed messages and information.

My email address : _____@_____

Patient Signature :_____ Date :_____