Ahmad Barakzoy, M.D. F.A.S.N.

Attention Patients

This annual update is to assist us in improving our communications with you and your health policy provisions. Please verify with staff current chart information to ensure correctness.

Thank You.

Patient Information **Update:**_______________

Name:________________________ **Date of Birth:**__________

Review Address:______________________________________

City/St:_____________________ **Zip:**___________

Phone: ( )_____________ **Home ( )**_________ **Work ( )** ________ **Cell**

Change in Martal Status: S M Other

Job or Occupation:______________________________

Employed by:___________________________________

Address____

Spouse (Name and Address, if different)______________________

Spouse's Date of Birth:____________ **Phone :**______________

Spouse's employer(if military): __________________________

Referred by:____________________ **_Specialty :**_____________

In Case of Emergency Notify: _______________ **Relation:** _______

Contact#:__________________

Consent for Release of Information must be signed (HIPAA Law)

Primary Care Doctor: _______________ **Phone #:**__________

Pharmacy Name:___________________ **Phone #:**___________

Update information as changes occur.

Ahmad Barakzoy, M.D., F.A.S.N.

PATIENT MEDICAL HISTORY

Today's date____________________

Name:____

Please list all surgeries you have had:

Surgery	Approximate Date

Do you smoke now? Yes____ No____ Have you ever smoked? Yes ____ No ____
Approximate dates you smoked and how many packs? ____________________
____

Alcohol: (circle one) Regularly Socially Never **Type:** Beer Wine Liquor

Children: Yes___ No____ How many?_____ Ages?________________

Do you have diabetes? _________ If yes, for how long? _______________
Are you on insulin? ___________ Pills: ______________

Do you have high blood pressure? Yes_______ No_______ If yes, for how long? ________

Medications: Please list here or give us a copy of a prepared list.
(Prescribed, Over the Counter, and supplements)

____
____
____
____

List any over the counter medications:

____
____
____
____

Pharmacy Name and location: ______________________________
Pharmacy #: _______________

This office forwards prescription electronically. Please supply a valid phone number to ensure you receive your medication.

Ahmad Barakzoy, M.D., F.A.S.N.

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________

I have been provided a copy of the notice of Privacy Practices for Ahmad Barakzoy, M.D., FASN. I acknowledge that I have fully read this notice and have had the opportunity to ask questions.

Patient's Signature: ______________________________ Date: ________________

Legal Representative Signature: ______________________ Date: ________________

Relationship: ______________________________

(If not signed by the patient, please indicate relationship.)

For Offical Use Only:

- Signed form received by: ______________________________
- Acknowledgement refused: ______________________________
- Efforts to obtain: ______________________________
- Reason for Refusal: ______________________________
- ______________________________

Ahmad S. Barakzoy, M.D., F.A.S.N.

CONSENT & ACKNOWLEDGEMENT
FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I am informed and understand that information about me in my medical record is protected as confidential under state and federal law as "Protected Health Information", and that no use or disclosure of any such information may be made without my consent or authorization.

2. I am informed and understand that Ahmad S. Barakzoy, M.D., FASN, in compliance with federal and Florida state law, requires that I provide my consent and authorization to use and disclosure of protected health information to carry out certain treatment, payment, or health care operations as a condition of receiving any medical care or treatment. I am further informed and understand that in normal circumstances, I am required to provide my consent in writing, but that in some circumstances, my consent may be inferred or implied by circumstances, such as seeking medical care or treatment.

3. I am informed and understand that my protected health information may be used and disclosed to carry out treatment, payment, or health care operations for my health care on the basis of my consent.

4. I am informed and understand that the nature and extent of the uses and disclosures by Ahmad S. Barakzoy, M.D., FASN, for treatment, payment, or health care operations which are within the scope of my consent are set out in a Notice of Privacy Practices, and that I have the right to review the Notice of Privacy Practices prior to signing this consent.

5. I am informed and understand that Ahmad S. Barakzoy, M.D., FASN, has reserved the right to change its privacy practices described in the Notice of Privacy Practices, and that I may obtain a revised Notice of Privacy Practices to the office staff of Ahmad S. Barakzoy, M.D., FASN.

6. I am informed and understand that:
   - 6.1 I have the right to request that Ahmad S. Barakzoy, M.D., FASN, restrict how my protected health information is used or disclosed to carry out treatment, Payment, or health care operations.
   - 6.2 I have the right to revoke my consent at any time, but that my revocation will Not be binding unless delivered to Ahmad S. Barakzoy, M.D., FASN, in writing,
   - 6.3 Any revocation of my consent will not be effective to the extent that Ahmad S. Barakzoy, M.D., has already taken action based on my consent prior to my Revocation in writing.

7. I am informed and understand that my consent is not effective unless signed and dated by me or within the provisions of federal and state law that permit my consent to be inferred or implied by any circumstances.

8. I hereby give my consent for uses and disclosures of my protected health information by Ahmad S. Barakzoy, M.D., FASN, for treatment, payment, or health care operations to the full extent set out in the notice mentioned above.

Signature: ______________________________ Date: ______________

Printed Name: ___________________________

MEDICAL RECORD RELEASE AUTHORIZATION

Date:____________________ Patient Name:____

DOB____________________SSN:_________________________________ Dates seen by PCP:_________ to__________

INFORMATION TO BE RELEASED/DISCLOSED **(PLEASE CIRCLE YES OR NO)**

Medical History	Yes/No	Outpatient/Emergency Records	Yes/No	Laboratory Reports	Yes/No
Medication Record	Yes/No	Pathology Reports	Yes/No	Radiation Reports	Yes/No
Treatments/Test	Yes/No	Other:____________________	Yes/No		

Demographics (limit to): ___ Name ___Age ___Address ___State/Zip code only
___Telephone ___Gender ___Race

DISCLOSURE PURPOSE

___Medical Treatment ___Patient Request ___Second Opinion ___Other____________________

I understand that this authorization will expire within two years from the below signed date.

I authorize the release of the above noted medical information to this specified representative, which may be acting on my behalf. (Each Person must be Listed)

________________________ ________________________ ________________________

(Representative Name) **(Relationship to Patient)** **(Patient Initial)**

I understand that these records are of privileged and confidential status. I waive that status for the purpose contained within this authorization. I further understand that the receiving organization authorized to receive this information if not a health plan or health care provider; the released information could potentially be re-disclosed and may not be protected by federal privacy regulations. I agree to hold Ahmad S Barakzoy, MD, harmless from any and all cost , liabilities, and damages of any nature, whatsoever, incurring attorney fee's resulting directly or indirectly from Ahmad S Barakzoy, MD release of these records pursuant to this content.

Legal guardian must sign if the patient is unable to sign due to mental/physical disability or in the case of a minor, authorization. To the recipient: Prohibitation of re-disclosure. This information is being disclosed to you from records whose confidentiality is protected by state law, specifically Florida statutes 395.3025, 455.667, and 394.459. State laws prohibit you from mailing or any further disclosure of this data without the specific written consent of the person to whom it pertains, or as otherwise permitted by state regulations. A general authorization is not sufficient for this purpose.

Ahmad S. Barakzoy, MD
1689 Eagle Harbor Parkway Suite B
Fleming Island, FL 32003
Tel: (904)579-3578
Fax: (904) 239-4283

Get Records From:
____
Address: ______________________________
____
State/ Zip:______________________________
Phone/Fax: ______________________________

I authorize and agree that I am financially responsible for the fees associated with my request: copying charges and postage related to the reproduction of this information. I understand that I may be charged for this service is $1.00 per page for the first 25 pages and $0.25 for each page thereafter, in accordance with Florida Administrative Code 64B8-1.0003.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTOOD THIS AUTHORIZATIONAND IT'S CONTENT.

______________________________ ______________________________

Patient/Guardian Signature Date Witness Date

Send by ___Mail ___Fax_________ (Patient must initial approval) Date Required: ____________________

It is the patient's responsibility to update or cancel persons who may obtain Health information.

Ahmad Barakzoy, M.D., F.A.S.N.

MEDICATION LIST

Patient Name: ____ DOB: ____________

Allergies: ____

Pharmacy: ______________________________ Pharmacy #: __________________

Date Began	Medication *(Prescription/Over-the Counter)*	Dosage	Refills Remaining

Patient's, please keep each of your physicians up to date with any medications, herbal supplements, or over-the-counter medications you are taking.

Ahmad Barakzoy, M.D., F.A.S.N.

NOTICE OF PRIVACY PRACTICES

Effective April 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duty to Protect Medical Information About You

We understand your medical information is personal and we are committed to protecting your medical information. We comply with legal requirement and provide you with the best quality of care. This notice will describe how we may utilize and disclose your medical information. This notice will also describe your rights regarding our use and disclosure of such medical information.

Our requirement by law is to ensure that identifiable medical information concerning you is kept private, provide you with this notice of our legal duties, your medical privacy and disclosure. We reserve the right to change our privacy practices and this notice at any time deemed necessary.

WE MAY DISCLOSE AND USE YOUR MEDICAL INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES.

To provide medical treatment to you, and to coordinate or manage your health care and related services. This may include communicating with various health care specialists regarding treatment and the management of your health care with others. Example: Disclosing your medical information concerning labs, prescriptions, or other healthcare services, such as referrals to health care providers.

We may disclose and utilize your medical information to **bill and receive payment for services.** Example: Forwarding a bill to your insurance company.

The information located on the bill may include personal identifying information, your diagnosis, supplies utilized, and treatment. This is provided to receive payment for medical services rendered. Expected treatment plans may be discussed to obtain insurer prior approval to determine whether your insurer will pay for medical treatment.

We will disclose medical information **for hospital and clinical operations** which will ensure you are provided with appropriate and quality patient care.

We will contact you concerning information concerning **treatment alternatives, specialist, health benefits for service**, or **appointments**.

We may disclose medical information to our **business associates** to care out payment, health care objectives, or treatment. Example: We utilize billing companies to process our medical claims to bill your insurance company for services rendered.

We will disclose medical information **when required by local, federal, or state law**. This requirement may be required for national security and intelligence objectives.

When necessary to prevent serious threat to **your health and safety** or the health and safety of others.

Members of the Armed Forces information may be released to their commands.

We may disclose your health information as required by law for **Public Health Services**, which may assist in preventing and controlled disability, injury, or disease, reporting births, mediation allergies, drug interactions, neglect, abuse, or domestic violence.

We may disclose your health information to an extent authorized by laws governing **worker's compensation** or similar programs, which may provide worker's benefits for related injuries or illnesses at the workplace.

We may disclose your health information to agencies that enforce licensure or accreditation requirements, such as **audits, inspections, or investigations**.

We may disclose your health information in response to a **court or administrative order**. This may in response to a subpoena, discovery, or lawful process, such as law enforcement. Example: We must comply will laws involve the reporting of specific wounds and physical injuries, i.e. dog bites, physical abuse.

We may disclose your health information to **medical examiners, funeral directors, or coroners** consistent with applicable laws to carry out their responsibilities.

We may disclose your health information to a **correctional facility** in which you may be in their custody, if required to maintain your health and safety

SPECIAL CIRCUMSTANCES

Alcohol, Drug Abuse, and Psychiatric Treatment Information have special privacy protections under the law. We will not disclose any medical information relating to these issues unless:

- Patient consents in writing.
- Court order requires disclosure.
- Medical emergencies
- Qualified personnel require for conducting financial audits, management audits, or evaluation.
- Necessary to report a crime or threat to commit a crime.
- To report neglect or abuse as required by law.

YOU MAY OBJECT TO CERTAIN USES AND DICLOSURES OF YOUR MEDICAL INFORMATION.

Unless you object in writing, we may use or disclose your medical information in the following circumstances.

Individuals involved in your care or payment for your care:

- Notify or assist in notifying a family member, legal representative, or another person responsible for your care.

- Emergency circumstances in the case of location and general condition, or disaster relief authorities.

OTHER PURPOSES OF MEDICAL INFORMATION

Disclosures of your medial information, other than those previously addressed or covered by law will only be made with your written permission. This authorization must be signed on a Medical Release for Authorization Form provided by our staff. **Spouses, family members may not be privileged to this information**, other than those identified previous, **without this written consent**.

You may provoke this permission, in writing, at any time. You should understand that all information disclosed prior to the revocation of this authorized permission are unable to be taken back and that we are required to maintain all records of the care provided to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the right to review and obtain copies of medical information used to make decisions concerning your medical care. This will involve the use for medical, administrative, and billing purposes, excluding psychiatric therapy notes related to your care. You may inspect and copy your information with a submission of request to the Medical Director or Administrator.

- If you request a copy, we may request a fee for costs incurred from copying mailing, or other supplies associated with this request. Under special limited circumstances, we reserve the right to refuse forwarding, copying this medical information.

Right to Amend your Information

If you think your medical information we have collected about you is incomplete, or inaccurate, you may request correction or the addition of information. You have the right to amend billing and clinical information concerning your care. This request must in writing and specified corrections should be detailed as to reasons for the amendment.

Reasons for denial of your request:

- Information created by another provider.
- Information is believed to be correct and complete.

We will forward specific documentation, if a denial for your request has been specified. If the request has been approved, reasonable efforts will be made to inform others as to the amendment.

Right to Accounting Disclosures

This is a list of the accounting of disclosure of medical information concerning you, outside the above specified disclosures authorized by you regarding billing, health collections, care operations, medical and psychiatric treatment, requests made by or that you authorized, permitted disclosures made to specialists involved in your care, or other purposes previously described.

In your request for the list of disclosures, please submit in writing to the Administrator. You must submit the time period no greater than six years and not prior to April 14, 2003.

Request for Restrictions

You have the right to request limitation or restriction to the medical information we disclose about your treatment, health care operations, or payment. *We do not have to comply with this request.* If we do agree to comply, we will comply with exception to the requirement to provide emergency treatment for you, required by the Secretary of the Department of Health and Human Services, and/or disclosures listed within this notice.

To request restrictions in writing:

- What information is to be limited.
- To whom you wish the limits to apply.

Changes to this notice

We reserve the right to change this notice at anytime. We reserve the right to make the revised or changed notice for medical information we already have about you, as well as, information to be received in the future.

Patient's Copy. Please keep copy for your review.