

# Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M. I: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ EXT: \_\_\_\_\_ Email Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Gender:  Male  Female  Transgender

Marital Status:  Married  Single  Divorced  Widowed

Ethnicity: \_\_\_\_\_

Student:  Not a student  Full-time student  Part-Time Student

Employer Name: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

\*\*\*\*\*If the person resides with you please give us a second contact person\*\*\*\*\*

2<sup>nd</sup> Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

## Insurance

Guarantor:

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Telephone: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

## Preferred Pharmacy

**Name:** \_\_\_\_\_ **Address/Phone:** \_\_\_\_\_

**Mail Order :** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone/Fax#** \_\_\_\_\_

**Primary Care Physician Name :** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Preferred Lab:** \_\_\_\_\_

# Scott D. McDowall, MD

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES		Mother    Father	ANEMIA		Mother    Father
HIGH BLOOD PRESSURE		Mother    Father	LEUKEMIA		Mother    Father
STROKE		Mother    Father	SICKLE CELL		Mother    Father
HEART ATTACK		Mother    Father	BLEEDING PROBLEMS		Mother    Father
ASTHMA		Mother    Father	STOMACH ULCER		Mother    Father
MIGRAINE HEADACHES		Mother    Father	GALLSTONES		Mother    Father
CANCER		Mother    Father	SEIZURES		Mother    Father
EMPHYSEMA		Mother    Father	TUBERCULOSIS		Mother    Father
KIDNEY PROBLEMS		Mother    Father	ALCOHOLISM		Mother    Father
ARTHRITIS		Mother    Father	SUICIDE		Mother    Father
GLAUCOMA / EYE PROBLEMS		Mother    Father	DEPRESSION		Mother    Father
SKIN RASH		Mother    Father	MENTAL ILLNESS		Mother    Father
OTHER		Mother    Father	OTHER		Mother    Father

**OPERATIONS / SURGERIES:** \_\_\_\_\_

Family History: Mother: \_\_\_Age \_\_\_Alive \_\_\_Deceased    Father: \_\_\_Age \_\_\_Alive \_\_\_Deceased

**OTHER HOSPITALIZATIONS:** \_\_\_\_\_

**BLOOD TRANSFUSIONS:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

**ALLERGIES:** (Any reaction to any medication of any kind?) \_\_\_\_\_

**OCCUPATION / WORK HISTORY:** \_\_\_\_\_

Any exposure to pesticides, chemicals, or other hazards?    YES \_\_\_\_\_    NO \_\_\_\_\_

If yes, What kind? \_\_\_\_\_

Family / Household: (Who lives at home with you?) \_\_\_\_\_

**HABITS:** Cigarettes: \_\_\_\_\_ PPD \_\_\_ X \_\_\_\_\_ years    Quit in \_\_\_\_\_ (year)

Other Tobacco Products? \_\_\_\_\_ Alcohol \_\_\_\_\_

Drug Use \_\_\_\_\_ Caffeine (coffee/colas) \_\_\_\_\_

Seat Belt Use: Yes: \_\_\_\_\_ No \_\_\_\_\_    Exercise: \_\_\_\_\_

### FOR WOMEN ONLY

Age of first menstrual period \_\_\_\_\_    How many days between periods? \_\_\_\_\_

How many days does it last? \_\_\_\_\_    Is bleeding heavy or light? \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_    Was it normal? \_\_\_\_\_

If menstrual periods have stopped, have you had any bleeding since? \_\_\_\_\_

Any Vaginal Discharge? Yes \_\_\_\_\_ No \_\_\_\_\_    Last Pap Smear \_\_\_\_\_

Method of Preventing Pregnancy: \_\_\_\_\_

Pregnancies \_\_\_\_\_    Births \_\_\_\_\_    Abortions/Miscarriages \_\_\_\_\_

Any other concerns? \_\_\_\_\_

**Name:** \_\_\_\_\_

**Social Security:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_

# HIPAA Notice of Privacy Practices

Effective as of April/ 14/2003 Revised March/26/2013

Scott McDowal1 PLLC 100 Whetstone Place, Suite 206  
St. Augustine, FL. 32086 Phone-  
904-429-9892

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternative or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

## USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) — Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information — This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

# HIPAA Notice of Privacy Practices (Cont)

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You have the right to request to receive confidential communications — You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information — If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures — You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach — We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

## COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

**HIPAA COMPLIANCE OFFICER Phone-904-429-9892 email-sgoode@flaglerfamilymedicine.com**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices. HCSI—  
Revised March 2013

## Acknowledgment of our notice of Privacy Practices

I hereby acknowledgment that I have received to have been given the opportunity to receive a copy of (Scott McDowall PLLC) Notice of privacy practices. By signing below, I am “only” giving acknowledgment that I have received or have had the opportunity to receive the notice of our privacy practices

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Patient name (Print)

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Patient’s Date of Birth

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Signature of Patient or Parent/Legal Guardian

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Date

## E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Scott McDowall LLC can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Understanding all the above, I hereby provide informed consent to Scott McDowall LLC to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

Print Patient Name

Signature of Patient or Guardian

Relationship to Patient

Patient DOB

Date



## **FINANCIAL POLICY for Scott McDowall M.D**

Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **Financial Policy**, which we require you to read and sign prior to any treatment:

1. All patients must complete our information and insurance form before seeing the doctor.
2. For your convenience we accept cash, check, Visa, MasterCard, American Express and Discover.

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. If we do not accept your insurance policy, as a courtesy, we will bill your company. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 45 days, the balance may be automatically transferred to your credit card or billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed, and payment is due upon receipt of bill.

**Regarding insurance plans where we are a participating provider:** All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional **Co-Payment, Deductible or Co-Insurance**. Please refer to your HealthCare Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

**Usual and customary rates:** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

**Minor patients:** The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, MasterCard, Discover or payment by cash or check at the time of service has been verified.

**Missed appointment:** Unless canceled at least 24 hours in advance, you may be subject to \$25.00 no-show fee at the physician's discretion. Please help us serve you by keeping scheduled appointments.

**Co-pays and Balances:** Co-pays are due at the time of service. If we need to bill you for the co-pay, there will be an additional \$5.00 processing fee. You will also be asked to pay any outstanding patient balance.

**Insufficient Fund Fee:** Checks that are returned will be charged a \$45.00 insufficient funds fee.

**Collection Fee:** Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for all fees and costs associated with collecting the balance.

Thank you for understanding our **Financial Policy**. Please let us know if you have any questions or concerns.

**I have read the *Financial Policy* and I understand and agree to its provisions.**

Date \_\_\_\_\_

Signature of patient or responsible party \_\_\_\_\_

# Authorization of Use and Disclosure of Protected Health Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

## I. My Authorization

You, Scott McDowall M.D may use or disclose the following health care information:

- ALL my health information maintained by you.
- My health information relating to the following treatment or condition: \_\_\_\_\_
- My health information for the date(s): \_\_\_\_\_
- Other: \_\_\_\_\_

You may disclose this health information to:

Name (or title) and organization: \_\_\_\_\_

Relationship: (parent, child, sibling, legal guardian, etc.): \_\_\_\_\_

Name (or title) and organization: \_\_\_\_\_

Relationship: (parent, child, sibling, legal guardian, etc.): \_\_\_\_\_

Name (or title) and organization: \_\_\_\_\_

Relationship: (parent, child, sibling, legal guardian, etc.): \_\_\_\_\_

This Authorization ends:  on (date) \_\_\_\_\_  
 When the following event occurs \_\_\_\_\_

## II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Dr. Scott McDowall at the address provided below. If I do, it will not affect any actions already taken by Dr. Scott McDowall based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

- 100 Whetstone Place Suite 206, St Augustine, FL 32086

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

\_\_\_\_\_  
Patient or legally authorized signature

\_\_\_\_\_  
Date

Patient is unable to sign because of (minor, disabled, etc.) \_\_\_\_\_



## Patient Portal Policy and Procedures

**Do Not use portal to communicate if there is an emergency.**

**Proper subject matter:**

- Prescriptions refills, medical questions, lab results, appointment reminders, routine follow up questions, etc.
- Sensitive subject matter (HIV, Hepatitis panels etc) are not permitted
- We do not refill controlled substance medications drugs on patient portal. You can request a refill but must come in to pick up the prescription or contact your pharmacy.
- Please be concise when typing a message.

**Current functionality of Patient Portal:**

- Email and secure messaging for Non-urgent needs
- Refill request (must include pharmacy info)
- Viewing of labs results that have been sent to you.
- Viewing and printing of continuity of health records
- Viewing and updating health information
- Viewing of selected health information (allergies, medications, current problems, past medical history). Note you can make changes/ additions to your health records, medication list, etc, but this will not change your permanent records without our review of the information,
- Referral requests
- Appointment request
- Billing questions
- Updating demographic information (address, phone #) and insurance information.

**All communication via portal will be included in your chart: Privacy:**

- All messages sent to you will be encrypted.
- Message from you to the staff should be through this portal or they will not be secure
- We will keep all email lists confidential and will not share this info with other parties.
- Any member of our staff may read your message or replay in order to help the Physician that has been email. This is similar to how a phone message is handled.
- Our system will check when messages are viewed, so you do not have to replay that you have read it

**Response time:**

- We will normally respond to non-urgent message inquires within a timely manner. Please contact the office if you need immediate response.

**I hereby request access to the patient portal maintained by Dr. Scott McDowall for the patient named below. I understand that Dr. Scott McDowall office take seriously its responsibility to safeguard the privacy of its patient and protect the confidentiality of their protected health information. Therefore, I will only access the patient portal in a matter consistent with these terms. I will keep safe the sign on and password that I am assigned and will not share my log in information with anyone else. I agree that Dr. Scott McDowall will not be liable for any disclosure of information due to the unauthorized use of my sign on and password. If I feel my sign on and password combination has been compromised, I will contact Dr. Scott McDowall immediately or go to the portal and request a new password. I understand that is the patient portal will allow me to view my records for the patient. If I accidentally gain access to another patient information, I will cease to view it and contact Dr. Scott McDowall immediately. In no event, will I deliberately attempt to access information for any person other than myself. I represent to Dr. Scott McDowall that I am personal representative of the patient with the right to access the patients' health information, or the patient has expressly authorized me to have access. If my status as a personal representative change so that I no longer have such rights, or if the patient authorization expires or is revoked, I will immediately cease using the patient portal to access the patient information and will notify Dr. Scott McDowall.**

**Email address:** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_

OR

**\_\_\_\_\_ Patient does not have an email address or Does not want access to patient portal**





**Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:**

**Patients in our practice may be contacted via email and/ or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/ information.**

**If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/ information at that email or text address from the practice.**

\_\_\_\_\_ (Patient initials) **I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communications as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/ feedback/ health information unless I request a change in writing (see revocation section below).**

**The cell phone number I authorize to receive text message for appointment reminders. Feedback and general health reminders/ information is \_\_\_\_\_.**

**The email that I authorize to receive email messages for appointment reminders and general health reminders/ feedback/ information is \_\_\_\_\_.**

**The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).**

**Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**Revocation:**

\_\_\_\_\_ **I hereby revoke my request for future communications via emails and/ or text messages.**

\_\_\_\_\_ **I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.**

**Note: This revocation only applies to communications from this practice.**

**Patient Name: \_\_\_\_\_**

**Patient/ Patient Representative Signature: \_\_\_\_\_**

**Date: \_\_\_\_\_**



Scott D. McDowall, M.D.

100 Whetstone Place Suite 206, St. Augustine, Florida 32086 PH: 904-429-9892 FX 904-217-7631

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Patient's Phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

I authorize Dr. Scott McDowall to **OR**  
**release** my medical information to:

I authorize Dr. Scott McDowall to  
**obtain** my health information from:

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Name of Provider or Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Phone# (include area code)

\_\_\_\_\_  
Phone# (include area code)

\_\_\_\_\_  
Fax# (include area code)

\_\_\_\_\_  
Fax# (include area code)

**PURPOSE FOR THIS REQUEST:** (check one)

Healthcare  Personal  Transfer of Care  Other Explain: \_\_\_\_\_

**TYPE OF RECORDS REQUESTED:** (Check One)

All medical records related to a specific illness or injury.

Specify illness/injury \_\_\_\_\_ Date(s) of treatment \_\_\_\_\_

Treatment Summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

Immunization History

Specific information (Select one or more as applicable):

Procedure Report  History & Physical  Laboratory test results  X-ray reports  HIV/AIDS

Psychiatric/Psychological evaluations/treatments  Drug and Alcohol Treatment Information

Other: \_\_\_\_\_

Copy of entire medical record as allowed by law.

**AUTHORIZATION VALID FOR:** (Check One)

This request only.

One year from the date of this authorization **OR** \_\_\_\_\_. (Insert date) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

This request **AND** for medical records of any **future** treatment of the type described above until \_\_\_\_\_ (insert date)

**I understand that:**

- My right to healthcare treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a **written** request to the address below except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by federal privacy regulations, the information stated above could be re-disclosed.
- Authorization for Release of HIV/AIDS related information, mental health, or substance abuse diagnosis and treatment information will expire in **60 days**.
- There may be a charge for the request records, following the Rule 64B8-10.003, Florida Administrative Code.
- For the first 25 pages, the cost shall be \$1.00 per page.
- For each page more than 25 pages, the cost shall be \$0.25 each. (please allow 7 business day for processing)

Signature of Patient/Legal Representative \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Signer: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_



Scott D McDowall, MD  
100 Whetstone place, suite 206  
St Augustine, FL 32086

### Advanced Care Planning Questionnaire

1. Do you have any spiritual or religious beliefs that would affect your care in the end of life? (for example, certain beliefs about the use of certain medical procedures). YES or NO
2. Would you want life prolonging measure if you were diagnosed with a terminal condition with no hope of meaningful recovery? YES or NO
3. Do you understand what life prolong measures are available such as CPR, defibrillation, mechanical intubation, IV fluids and antibiotics, artificial feeding and hydration via IV or enteral tube? If no please ask your healthcare provider to explain. YES or NO
4. Do you want life prolong measure such as CPR? YES or NO
5. Do you want life prolonging measure such as defibrillation? YES or NO
6. Do you want life prolonging measure such as mechanical intubation? YES or NO
7. Do you want life prolonging measure such as IV fluids or antibiotics? YES or NO
8. Do you want life prolonging measure such as artificial feeding and hydration via IV or enteral tube? YES or NO
9. Do you have a plan of care if you are unable to speak? YES or NO
10. Have you selected a health care proxy or alternate? YES or NO
11. Have you discussed your wishes with your health care proxy or alternate? YES or NO
12. Do you have a DNR? YES or NO
13. Do you have a living will? YES or NO

Patient name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Refused: \_\_\_\_\_