CFHC
Central Florida Heart Center
AJAY J. MEHTA, MD

CONFIDENTIAL
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

*NAME OF PATIENT: _____

*DATE OF BIRTH: _____ SS# _____

I HEREBY AUTHORIZE: _____

_____

_____P: _____F: _____

I request that any and all records specified below be released to:

Ajay J. Mehta, MD
3310 SW 34th Street, Ocala, Florida 34474
Phone: 352.789.6931
Fax: 352.387.0189

- ☐ Labs- Last 6 months
- ☐ LAST Office note- ONLY LAST OFFICE NOTE
- ☐ Operative – Catheterization, CABG, etc.
- ☐ Stress Testing/Echocardiogram, EKG, Holter/Event Monitors
- ☐ Carotid US, ABI's, LE Venous/Arterial, Etc.
- ☐ Hospital Records within last __12___ months
- ☐ Other: ALL PERTINENT CARDIAC RECORDS/CONTINUED CARE

Please be advised that this is to be considered a full and complete authorization and that the provider/facility/insurance company listed above as the releasing agency is released from all legal liability that may arise from the release of the information requested.

I further understand that I am authorizing the release of information from the records whose confidentiality and privileged status is protected from Federal Regulations and Florida Statue and that a re-disclosure of this information by the receiving agency is prohibited without written express permission from the patient.

*Signature: _____ Date: _____
Witness: _____ Date: _____

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CONFIDENTIAL
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NAME OF PATIENT: _____

DATE OF BIRTH: _____ SS# _____

I authorize the following people to receive information regarding my medical condition:

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) Provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is available in the office and posted on the wall.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

Patient information will be kept confidential except as is necessary to provide services or to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least, temporarily, in administrative areas such as the front office, examination rooms, etc., those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents of information.

This authorization is subject to written revocation at any time except to the extent that action has already been taken in reliance, on the authorization. If not previously revoked, this authorization will terminate one (1) year from the date of signature.

By my signature below, I am acknowledging my review and understanding of the above HIPAA Information and CONSENT on the date set for below.

Signature: _____ Date: _____

Witness: _____ Date: _____

CENTRAL FLORIDA HEART CENTER
AJAY J. MEHTA, M.D. FACC
3310 SW 34th Street, Ocala, FL 34474
Phone: 352.789.6931 ** Fax: 352.387.0189

PATIENT INFORMATION

PRIMARY CARE DOCTOR: _____

Last Name:	First Name:	MI:	DOB:	Age:

Phone: ( )	Cell Phone: ( )	Social Security: / /	Sex: (Circle One) Male Female

Marital Status: (Check One) Single: ___ Married: ___ Divorced: ___ Separated: ___ Widowed: ___

Street Address: Apt/Lot:

City:	State:	Zip:	Email Address:

How were you referred to us: (Check One)
Dr: ____ Family: ____ Friend: ____ Insurance: ____ Hospital: ____ Other: _____

INSURANCE INFORMATION

Name of Insurance: (Primary)	Policy No:			Group No:
Relationship to Subscriber: (Check One)	Self: ___	Spouse: ___	Child: ___	Other: _____
Subscriber Name: (If different from above)	DOB: /		Social Security No: / /	
Name of Insurance: (Secondary)	Policy No:			Group No:
Relationship to Subscriber: (Check One)	Self: ___	Spouse: ___	Child: ___	Other: _____
Subscriber Name: (If different from above)	DOB: /		Social Security No: / /	

IN CASE OF EMERGENCY

Name of Friend/Relative:	Phone: ( )	Relationship to patient:

ADVANCED DIRECTIVE (Please check all that apply to you and bring with you to put it on file)

DNR - Do not resuscitate ___	**JW** - Jehovah Witness ___	**LW** - Living Will ___
NAD - No Advanced Directive ___	**OD** - Organ Donor ___	**POA** - Power of Attorney ___

INSURANCE ASSIGNMENTS AND AUTHORIZATION TO RELEASE INFORMATION

I do hereby authorize any physician examining and/or treating me to release to any third payor (such as insurance company or government agency) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for apyment for such treatment and/or diagnosis. I do hereby authorize payment directly to any physician examining or treating me for medical benefits, otherwise payable to me for their services, but not to exceed the reasonable and customary charge for these services. I hereby certify all insurance pertaining to treatment shall be assigned to the physician treating me. I permit a copy of these authorizations and assignments to be used in place of the original which is on file at the physician's office. I agree that should the amount o fthe insurance benefits be insufficient to cover the expensed that i will be responsible for payment of the difference. I will be responsilbe ofr the entire amount due for professional services rendered if the expense is not covered by my policy, or if uninsured. Thank you Central Florida Heart Center (CFHC)

*****Make sure you filled in your Primary care doctor******

Signature: _____ Date: _____

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Name: **DOB:** / / **Todays Date:** / /

MEDICAL HISTORY

CARDIOVASCULAR:

Y / N	Abnormal EKG	Y / N	Congestive Heart Failure
Y / N	Angina/ Chest Pain	Y / N	Coronary Artery Disease
Y / N	Chest Pressure	Y / N	Ischemic Cardiomyopathy
Y / N	Hypertension	Y / N	Pacemaker/ Defibrillator
Y / N	Hyperlipidemia	Y / N	Atrial Fibrillation
Y / N	Syncope/ Fainting	Y / N	Heart Valve disease
Y / N	Heart Murmur	Y / N	Carotid Artery Disease
Y / N	Palpitations	Y / N	Peripheral Artery Disease
Y / N	Diabetes	Y / N	Blot clots: **Where**_____ **Date** _____
Y / N	Claudication	Y / N	Stroke/ TIA/ CVA: **Date**_____
Y / N	Cardiac arrhythima	Y / N	Heart Valve replacement: **Date:**_____
Y / N	Bradycardia	Y / N	Previous Heart Attack? **Date:** _____

PULMONARY/ LUNGS:

Y / N	Asthma	Y / N	Pneumonia
Y / N	COPD	Y / N	COVID + **Date:**__/__/_____
Y / N	Chronic Cough/ Wheezing	Y / N	Other:

HOSPITALIZATIONS: (Where, Reason, Dates)

SURGERIES:

CARDIAC TESTING:

Cardiac Cath:	Y	N	Date:	Where:
Echocardiogram:	Y	N	Date:	Where:
Stress Testing:	Y	N	Date:	Where:

PHARMACY: **PHONE:**

MAILORDER: **PHONE:**

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SOCIAL HISTORY					
Tobacco Use:	Never ____		Former: ____ **Quit Date:** ____/____/_____		
Current Smoker: ___ **Start Date:** ___/___/_____			**# Packs per Day?** _____		
Alcohol Use:	Y ____	N ____	# Per Day _____		# Per week: _____
Caffeine Use:	Coffee	Y / N	# Per Day	_____	# Per week: _____
Caffeine Use:	Tea/ Soda	Y / N	# Per Day	_____	# Per week: _____
Exercise:	Y	N	How many days per week? _____		

MEDICATION ALLERGIES:

CURRENT MEDICATIONS: (Please include dosage (mg) and how many times a day)

FAMILY HISTORY OF:	**Father:**		**Mother:**		**Grandparents**	
Alive?	Y	N	Y	N	Y	N
Coronary Artery Disease	Y	N	Y	N	Y	N
Diabetes	Y	N	Y	N	Y	N
Hypertension	Y	N	Y	N	Y	N
Heart disease	Y	N	Y	N	Y	N
Stroke	Y	N	Y	N	Y	N
Mental illness	Y	N	Y	N	Y	N
Cancer	Y	N	Y	N	Y	N
Other/unknown	Y	N	Y	N	Y	N
Kideny disease	Y	N	Y	N	Y	N
Congestive Heart Failure (CHF)	Y	N	Y	N	Y	N
AAA	Y	N	Y	N	Y	N
Atrial fibrillation (Afib)	Y	N	Y	N	Y	N
MI/ Heart attack	Y	N	Y	N	Y	N
Cardiac dysrhythmia	Y	N	Y	N	Y	N
High Cholesterol	Y	N	Y	N	Y	N

SIBLINGS: Y / N	# of Brothers ____	# of Sisters ____	Healthy? Y / N
Children: Y / N	# of Sons ____	# of Daughters ____	Healthy? Y / N
SIGNATURE:		**DATE:**	