FLORIDA HEALTHCARE ASSOCIATES

2021 PATIENT DEMOGRAPHIC UPDATE

So we may better serve you, please provide your current address and pharmacy information

PATIENT NAME:____

PATIENT DATE OF BIRTH: ___________________________________

ADDRESS:____

____

MAIN PHONE NUMBER: (______)_____________________________
○ Mobile ○ Home ○ Work

ALTERNATE PHONE NUMBER: (______)______________________
○ Mobile ○ Home ○ Work

PLEASE PROVIDE INSURANCE CARD(S)

PHARMACY INFORMATION

PHARMACY NAME:____

PHARMACY ADDRESS: ________________________________

(or cross streets)

FHA 2021 1

FLORIDA HEALTHCARE ASSOCIATES

MEDICAL RECORDS RELEASE

I, __________________________request all medical records including but not limited to: EKGS, BLOOD RESULTS, X-RAY AND ULTRASOUND REPORTS, OPERATIVE REPORTS, CARDIAC CATH REPORTS, PACER AND DEFIBRILLATOR STRIPS AND SETTINGS, THALLIUM STRESS TEST REPORTS, PSYCHIATRIC RECORDS and any other information pertaining to my health to be released to:

FLORIDA HEALTHCARE ASSOCIATES

MITCHELL LAMPERT, M.D.
ROOPTAZ SIBIA, M.D.
ALEX ZOPO, M.D.
CHRISTOPHER HUNT, M.D.
AARON COHEN, M.D.
NICOLLE MELENDEZ, P.A.
ORLY MATHESON, P.A.

11195 JOG ROAD, SUITE 3
BOYNTON BEACH, FL 33437
PHONE (561) 733-9690
FAX (561) 733-9626

709 S. FEDERAL HWY, STE 5
BOYNTON BEACH, FL 33435
PHONE (561) 836-8600
FAX (561) 736-7191

PRINT PATIENT'S NAME: ______________________________
DATE OF BIRTH: ______________________________________
LAST 4 DIGITS OF SSN:__________________________________

SIGNATURE: ____

WITNESS: ____

Florida Healthcare Associates

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Boynton Beach, FL 33437
T: (561) 733-9690
F: (561) 733-9626

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION

The following information is required in order for us to provide a family member (i.e. spouse, parent, son or daughter) or caretaker any of your personal medical information. This includes, but is not limited to, diagnosis(s), test results, medications or anything else pertaining to your care within our practice. Please fill out the information below listing the person(s) name that is authorized to receive your private information. If this does not apply to you currently, please disregard; however, should the need arise for you to fill out this form in the future, please ask someone at the front desk and we will be happy to assist you.

Patient Name: ____

Patient Address: ____

Date of Birth: ____

I ______________________________ allow the following persons(s) to view my protected health information.

Name/Telephone#:____

____

____

Patient please note: The practice is not required to agree to your request. Please see our Notice of Privacy Practices for more information regarding such requests.

Patient's signature: ___________________________________ Date: ______/_____/_______