

Waseem Alhushki, MD
Kanyalakshmi Ayyanar, MD
Danielle Bello, PhD
Angela Berg, DNP, CPNP
Diane Brown, MD, PhD



Jennifer Buitrago, APRN
Alan Ikeda, MD
Joseph Lasky, MD
Nicola Longo, MD, PhD
Katherine Marzan, MD
Nik Abdul Rashid, MD

Welcome to the offices of Cure 4 the Kids Foundation. We appreciate the confidence and trust that you have placed in our office and look forward to meeting you personally and professionally. Our goal is to provide the highest quality care in a friendly, caring and efficient environment

It is also our goal to provide you timely visits with your physicians. Please arrive on time to your appointment with paperwork completed to avoid the risk of your appointment being rescheduled.

We ask that you bring the following items to our office for your first visit:

- All over-the-counter, herbal and prescription medications that the patient is taking
- Current insurance card & driver's license or government issued photo ID
- CD/Films for any CT scans, ultrasounds or testing you have had done

Our office is located at One Breakthrough Way, Las Vegas, NV 89135 (closest intersection is 215 and Town Center Dr.).

Should you have any questions or need any additional information please don't hesitate to call our office at 702-732-1493.

We look forward to seeing you at our office. Thank you for giving us the opportunity to serve you.

Sincerely,

The Staff of Cure 4 the Kids Foundation

Waseem Alhushki, MD
 Kanyalakshmi Ayyanar, MD
 Danielle Bello, PhD
 Angela Berg, DNP, CPNP
 Diane Brown, MD, PhD



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Patient Registration & Insurance Information

Please verify patient's information and change if incorrect. The front desk is available if you have any questions.

ALL ITEMS MUST BE COMPLETED – DO NOT LEAVE ANY BLANKS

PATIENT INFORMATION									
PATIENT NUMBER			DATE						
PATIENT LAST NAME			FIRST NAME		MIDDLE INIT	SSN		SUFFIX	
ADDRESS 1					CITY		STATE	ZIP	
HOME TEL #			WORK TEL #		CELL #		SEX	AGE	
BIRTHDATE		EMPLOYER			E-MAIL ADDRESS				
USUAL PROVIDER				REFERRING PHYSICIAN			PRIMARY CARE PHYSICIAN		
MARITAL STATUS		EMPLOYMENT STATUS <input type="checkbox"/> Full <input type="checkbox"/> Part <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed			STUDENT STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not a Student			REL TO GUARANTOR	
PREFERRED PHARMACY & LOCATION (INTERSECTION)					PREFERRED PHARMACY PHONE #				
ETHNICITY <i>(select 1)</i> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown/Refused					LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> _____			INTERPRETER NEEDED <input type="checkbox"/> Yes <input type="checkbox"/> No	
RACE <i>(select 1)</i> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown/Refused									

INSURANCE INFORMATION									
PRIMARY INSURANCE					SECONDARY INSURANCE				
CARRIER NAME					CARRIER NAME				
CARRIER ADDRESS					CARRIER ADDRESS				
CERTIFICATE ID #					CERTIFICATE ID #				
GROUP NAME					GROUP NAME				
CLAIM/GROUP NO					CLAIM/GROUP NO				
CARRIER PHONE #					CARRIER PHONE #				
SUBSCRIBER NAME					SUBSCRIBER NAME				
SUBSCRIBER D.O.B.					SUBSCRIBER D.O.B.				
SUBSCRIBER SSN					SUBSCRIBER SSN				
RELATIONSHIP TO PATIENT					RELATIONSHIP TO PATIENT				

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)									
GUARANTOR LAST NAME				FIRST NAME			MIDDLE INIT		
ADDRESS					CITY		STATE	ZIP	
HOME TEL #		WORK TEL #		CELL #		E-MAIL ADDRESS			

EMERGENCY CONTACT INFORMATION									
1	EMERGENCY CONTACT #1							SUFFIX	
	PHONE #1		PHONE #2		PHONE #3			RELATIONSHIP TO PATIENT	
2	EMERGENCY CONTACT #2							SUFFIX	
	PHONE #1		PHONE #2		PHONE #3			RELATIONSHIP TO PATIENT	

Patient Health History Questionnaire

Please help us be as efficient as possible with your first visit to our clinic. This health history questionnaire **must** be completed prior to your appointment. Should you need assistance with answers to any of the questions asked, feel free to contact our office and we will be happy to help you.

Health history questionnaires that are incomplete or forgotten at the time of your appointment and/or arriving late for your appointment may result in rescheduling of your appointment.

TODAY'S DATE	DATE OF LAST PHYSICAL EXAM	<input type="checkbox"/> Unknown
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Mail Order Pharmacy (if applicable)		
Name	Address	
Phone	Fax	

Reason For Visit What is the main reason the patient is seeing the doctor today?
<input type="checkbox"/> Referred by Hospital or Other Provider. Who?

Past Medical History Has patient ever been DIAGNOSED with any of the following problems? If yes, please explain.					
		DATE OF ONSET	DATE OF TESTING	COMMENTS	RESOLVED?
AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Indicate type(s)					□
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Insulin Dependent (Type I)	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Non Insulin Dep (Type II)	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Indicate type(s)					□
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Neurological Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Stomach or Intestinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Urinary Tract Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No				□
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No				□

Allergies List patient's allergens and associated reactions (e.g. Hives, Rash, Nausea...)					
<input type="checkbox"/> No Known Drug Allergies					
<input type="checkbox"/> No Known Food Allergies					
Allergen & Allergic (Y/N)		Reaction	Allergen & Allergic (Y/N)		Reaction
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Morphine	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Adhesive tape	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Family History Check if patient's blood relatives have had any of the following, If yes, please specify.						
<input type="checkbox"/> Family Medical History Unknown						
	Mother	Father	Sister(s)	Brother(s)	Other	Please Mark if Not Present
Date of Birth (DOB)						
Health State (Good, Fair, Poor)						
Age of Death						
Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer – Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease-Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Premature Death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medications: Please list patient's medications including aspirin, vitamins, over-the-counter, or herbal medications.					
Medication Name	Dose	Frequency & Reason	Medication Name	Dose	Frequency & Reason
			Aspirin		
			Coumadin/Warfarin		
			Hormones or birth control		
			Herbal supplements		
			Vitamins		

Social History of Patient:	
Single parent household <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable	Split custody? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
Who lives in household with child <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Others _____	
Are there any safety concerns in the household? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Lives in <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Trailer <input type="checkbox"/> Other _____	
Smokers in household? <input type="checkbox"/> Yes <input type="checkbox"/> No	Caretaker smokes? <input type="checkbox"/> Yes <input type="checkbox"/> No
School? <input type="checkbox"/> Day care <input type="checkbox"/> Preschool <input type="checkbox"/> Home school <input type="checkbox"/> Traditional school Grade _____	
Extra-curricular activities <input type="checkbox"/> Sports <input type="checkbox"/> Arts <input type="checkbox"/> Crafts <input type="checkbox"/> Other _____	
Does the patient use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No

Birth History of Patient:	
Pregnancy/medical problems <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe _____	
Delivery <input type="checkbox"/> Normal <input type="checkbox"/> Prolonged <input type="checkbox"/> Difficult <input type="checkbox"/> Vaginal <input type="checkbox"/> C/Section <input type="checkbox"/> Breech <input type="checkbox"/> VBAC <input type="checkbox"/> Other _____	
Birth <input type="checkbox"/> Full term <input type="checkbox"/> Premature Number of weeks _____	

Past Surgical History or Hospital Stays for Patient:		
History of anesthesia problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type and reactions _____		
Year	Procedure/Illness	Surgeon/Location

Recent Imaging and Diagnostic Studies for Patient: (CT, X-ray, Ultrasound, MRI, etc.)			
Year	Type	Body Part	Facility
	CT Scan		
	X-Ray		
	MRI		
	Ultrasound		

Review of Systems: Please tell us about the patient's current symptoms .					
* General		* Cardiovascular		* Musculoskeletal	
Normal: Activity Level	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Normal Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Normal Sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Normal Growth/Development	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Neurological	
Normal Speech/Language	<input type="checkbox"/> Yes <input type="checkbox"/> No			Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
		* Gastrointestinal		Serious Head Injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No
* Skin		Abdominal Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Concerning Moles/Bumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Psychiatric	
				Uncooperative/Defiant	<input type="checkbox"/> Yes <input type="checkbox"/> No
* Head & Neck (HEENT)		* Genitourinary		Anxious/Depressed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty with Teachers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Concerns w/ Bladder Control	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty with Children	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Concerns w/ Bowel Control	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Itchy Watery Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Endocrine/Hematopoietic	
Stuffy Nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	Concerns w/ Sexual Development	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty with Heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neck Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Side (flank) Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty with Cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Urinary Complaints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
* Respiratory				Excessive Urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Females Only		Easy Bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Missed Periods	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Menstrual Irregularities	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Please list any doctors that you are currently seeing as a patient:			
Doctors Name	Phone Number <i>(if known)</i>	Type of Doctor	Condition Being Treated

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Patient Name: _____ Date of Birth: _____

If you have insurance, Cure 4 the Kids Foundation will gladly process your claim. However, we require that your estimated portion is paid when services are rendered.

IF YOU ARE NOT COVERED BY INSURANCE, we will provide an estimate of the cost of your care. This estimate will include anticipated charges based on the recommended treatment plan. If your plan of treatment changes, you may be asked to agree to a new estimate and estimates may vary due to a variety of factors.

If you are a **SELF-PAY** patient or if you have a financial obligation after your insurance has fulfilled its responsibility, you will be expected to pay the balance due. If you cannot pay your balance in full, payment arrangements may be possible. For payment options, including sliding fee scales, you must speak with our Business Office Representative.

For further understanding of our billing process, please feel free to contact a member of the business office staff.

Please initial each line:

_____ I request that payment of authorized insurance benefits, including Medicare if I am a Medicare beneficiary, be made on my behalf to C4K for all pharmaceuticals, tests, procedures, equipment, supplies, physician/nursing services--including major medical benefits, or services provided to me by C4K.

_____ I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for the above mentioned medical services to C4K, my insurance carrier, state, federal accreditation agency, or other medical entity. A copy of this authorization will be sent to my insurance carrier, or other medical entity, if requested. The original authorization will be kept on file by C4K. I also agree to a review of my records for purposes of internal audits, research and quality assurance reviews within C4K.

_____ I understand that it is my responsibility to notify C4K of any changes in my health care coverage, insurance carrier, change of address, change of employer or any change in legal guardianship of the minor/patient.

_____ I understand that I am financially responsible to C4K for any charges not covered by health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by C4K and/or my health care insurer, if the submitted claims or any part of them are denied for payment. I understand that by signing this form I am accepting financial responsibility and am agreeing to pay for any/all above described medical services received. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for service.

_____ I understand that there is a **\$25.00** charge for all returned checks.

_____ I understand that there is a **\$25.00** charge for all missed or cancelled appointments that are not cancelled within 24 hours of the scheduled appointment time.

**** THIS ACKNOWLEDGEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING ****

*By signing this document, I also acknowledge that I have been made aware of C4K's **Notice of Privacy Practices**, as is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights as well as **Understanding our Billing Process**. I have read and, if requested, received a copy of the above statement and Privacy Practices and accept the terms. A duplicate or facsimile transmission of this statement is considered the same as original.*

Signature of Insured/Parent/Guardian: _____ Date Signed: ____/____/____

Print Name of Insured/Parent/Guardian: _____

AUTHORIZATION OF TREATMENT AND DISCLOSURE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize **Cure 4 the Kids Foundation** to treat myself or my child as needed and not hold them responsible for any decisions made in an emergency situation.

No medical information with any third parties will be discussed, unless written consent/authorization has been obtained. This includes discussion by telephone, facsimile, letter, email or in person. This consent form gives C4K permission to discuss medical information for the purpose of administering health care related activities. I hereby agree that Protected Health Information (PHI) may be released by C4K as stated in our clinic's '*Notice of Privacy Practices*.'

I authorize only the following individual(s) to accompany minor child/patient to appointments and receive Protected Health Information (PHI) concerning the above named minor child/patient (act as "personal representative(s)" or loco parentis for the above named minor child/patient), in accordance with NRS 129.030 - 129.040:

Printed Name: _____ Relationship to Patient: _____

Printed Name: _____ Relationship to Patient: _____

I further certify that I am the legal parent/guardian of the above named minor child/patient.

Signature of Insured/Parent/Guardian: _____ Date Signed: ____/____/____

Print Name of Insured/Parent/Guardian: _____

Employee Witness: _____

AUTHORIZATION TO RELEASE PATIENT MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____

Release Information to:

Cure 4 the Kids Foundation

One Breakthrough Way

Las Vegas, NV 89135

Phone: (702) 732-1493

Fax: (702) 732-1080

Release:

All Records Labs/Radiology Notes

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Cure 4 the Kids Foundation (C4K) in writing. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Nevada privacy regulations.

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

Printed Name of Person Requesting: _____ **Phone Number:** (____) ____ - _____

Relationship to Patient: Patient Parent Guardian Other _____

Authorizing Signature: _____ **Date of Signature:** ____/____/____

**THIS AUTHORIZATION IS VALID FOR ONE YEAR FROM THE DATE SIGNED
UNLESS I SPECIFY ANOTHER DATE: ____/____/____.**
