Welcome to

Lady Lake Family Medicine

1. **We are glad you have chosen us for your primary medical care.** We will promise to help provide you with the medical information and services you need in a timely fashion and supportive environment.

2. **What is Primary Care?** It is the first level of continuing medical care where you begin access to all other branches of medicine. It may be all you ever need if you are healthy or it may be where we decide what specialty care you also need. We do routine health maintenance as well as more intricate care.

3. **What is a Family Medicine Specialist?** More than just a General Practitioner, a family doctor is residency trained (3 additional years) and board certified just like any other specialist, they just deal with a little of everything instead of a lot of one thing. They are trained by specialists in all the major fields (surgery, ob/gyn, psychiatry, internal medicine, urology, cardiology, dermatology, etc.) to do many of the same treatments and procedures, but to also know the safe limits of their knowledge and to refer out when they cannot provide more detailed care.

4. **What is a D.O.?** He/she is a medical doctor just like any M.D., but one who has undergone additional training in muscular-skeletal medicine. Only M.D.'s and D.O.'s are allowed by the state and national government to call themselves doctors and practice all aspects of medicine and surgery.

5. **Who is Doctor Burress?** He is a third generation Floridian who went to U.C.F. for simultaneous double degrees in biology and psychology. He worked and did research for a neuropsychologist until he was accepted at N.S.U. in Miami where he received his medical degree in 1998. He did his internship near Tampa, FL and his family medicine residency in Orlando at Florida Hospital, one of Florida's largest medical institutions. Just prior to starting this practice he was Medical Director for a corporation that had multiple urgent care facilities in the area.

6. **What an Advanced Registered Nurse Practitioner (ARNP)?** A FNP has graduated as an Advanced Registered Nurse Practitioner with a focus in Family Medicine and Care. A FNP can see patients starting at 1 year of age and throughout their lives. An ARNP is Licensed & Registered in the state in which they practice. ARNPs also deliver a broad range of medical and surgical services, including: * Conducting physical exams * Obtaining medical histories * Diagnosing and treating illnesses * Ordering and interpreting tests * Counseling on preventive health care * Assisting in surgery & * Prescribing medications.

7. **Who is Karen Callahan, DNP?** . She is a true Floridian, born and raised right here in Lake County, Florida. She has been a nurse serving the geriatric community in Lake County for over 17 years. Karen received her Master of Nursing in Science from South University in Tampa, FL with a specialty in Family Nurse Practitioner. She is board certified by the AANP (American Association of Nurse Practitioners). She continues to provide care in the community to make a difference in healthcare and to help patients make better health choices. Karen states, "To wake up each morning and know that I have the opportunity to save or prolong a life with my knowledge and skills is a gratifying factor".

8. **Who is Ronald Kope, APRN?** Ron was born and raised in Wheeling, WV and has had a desire to serve in the medical community for as long as he can remember. His medical service started as a paramedic with the Wheeling Fire Dept where he worked and continued to advance his education by going to school for nursing. He completed his undergraduate education at West Liberty University and continued to graduate school with his Master of Nursing in Science at Franciscan University in

Steubenville, OH and is board certified by the ANCC (American Nurses Credentialing Center). He started his APRN career in family medicine/urgent care in Wheeling before moving to Naples, FL in 2015 and eventually relocating to Summerfield in 2022. He has provided care in Family Medicine and also has a background in Cardiology. His passion is with primary care which allows him to be able treat the whole person and to develop long standing, caring relationships with patients to help guide them in their healthcare.

Noteworthy Notes

1. **Time Policy -** We strive to be on time all the time. The nature of medicine is such that issues often come up that need to be dealt with immediately. Please know that we are always aware that your time is important and that your issues will also receive the same attention when needed. We cannot control it if someone comes in with a heart attack or a hospital E.R. calls. If you are late, please be aware that we may have already moved on to the next scheduled patient and we will try to work you back into the schedule, but that may not always be possible.

2. **Hospital -** In an effort to stay on time, Dr. Burress does not currently see patients in the hospital. He does have a hospitalist, Dr. Zaman, (a doctor that only sees patients in the hospital) on call for his patients 24 hours a day should you need to be hospitalized.

3. **Prescription Refills -** Please remember that we are seeing patients all day. You are aware of when your prescriptions will run out ahead of time, so please call for an appointment in advance. Almost all medications require a medical visit and/or tests prior to refill, even if you have been on the medicine a long time (diabetes, high blood pressure, and high cholesterol are among many that often need labs before they can be refilled).

4. **Biopsies -** If there is a suspicious lesion, the Provider may recommend taking a sample of it. Please be aware that there is a fee for both the biopsy and the microscopic examination. Only the biopsy fee is under our control, the laboratory sets the other charges.

5. **Charges -** This should not have to be said, but it may relieve your worries in some cases to state at the outset. We will never recommend a test that we don't think you need in some misguided attempt to make money. On the same tact, we will always inform you of necessary tests regardless of your insurance or ability to pay. We may be able to modify prescriptions or tests to help comply with insurance plans but we practice medicine, not economics. If you have a billing question, feel free to contact our billing department.

6. **Labs -** When we recommend blood work, x-rays, or other exams, these tests will incur a separate charge even if we collect a lab sample or arrange the procedure for you as a courtesy. We have no control over how much laboratories charge for their services. **We do not** get kickbacks or other incentives from any facility we send you or your specimen to.

7. **Payment -** Payment is due at the time services are rendered. If we accept your insurance we will bill them for you as a courtesy, however the responsibility remains with you for full payment. Ninety days after a correct claim has been sent, all unpaid bills become the patient's guarantor's sole responsibility. In the interest of providing care to all, an affordable payment plan may be arranged.

8. **Other Providers -** If other doctors are involved in your care, it is your responsibility to make the staff aware of any changes that may have occurred since your last visit. This is why **all prescription medication bottles must be brought to all your visits or a very accurate list.** The Provider may choose to not see you unless you have all your medications with you. We work with other Providers to double check this, but many patients see several doctors and may have the same drug addressed by

more than one doctor. We will designate one prescribing doctor for a drug and you should stick to that Provider for refills unless otherwise informed.

Thank you for choosing

Lady Lake Family Medicine

If you have any questions or concerns, please do not hesitate to contact us.
We look forward to working with you towards your continued good health.

Lady Lake Family Medicine
John D. Burress, D.O.
Karen Callahan, DNP
Ronald Kope, APRN

Patient Medical History Form

Print Name: _____ Date of Birth: _____

Date: _____ SSN# _____ State of Full-Time Residence: _____

Circle: Single, Married, Divorced, or Widowed. Race: _____ Ethnicity: _____ Language(s): _____

Drug Allergies: _____

Occupation: _____

Current Medications:

Medication Name	Dosage Strength (mg)	Directions (take # per day)	Prescribed by
Example: Tylenol	500mg	2 tablets once a day in the mornings	Dr. Who

Your Medical History: **(circle if you have/had any of the following)**

Measles/Mumps
Diphtheria
Chickenpox
Shingles
Flu

Allergies
Frequent Infections
Cancer:_____

Diabetes
Insulin Use
Thyroid Disease
Hair Loss
Fatigue- Chronic
Weight Loss or Gain- recent
Post Menopause

Headaches
Migraines
Dizziness, Fainting, Vertigo
Seizures/Convulsions
Neuropathy
Numbness- hands/feet
Tingling- hands/feet
Tremors

Vision changes
Glaucoma
Macular Degeneration
Eye infections
Hearing decreased
Ear infections/problems
Nose Bleeds
Nose/Sinus problems
Throat/Mouth problems
Swallowing difficulty

Chronic Cough
Bronchitis
Asthma/Wheezing
COPD
Emphysema
Tuberculosis
Pneumonia
Shortness of Breath

Stomach/Abdominal Pain
Nausea / Vomiting
Diarrhea / Constipation
Colitis, Ulcerative Colitis
Crohn's disease
Irritable Bowel Syndrome
Change in Bowel Habits
Blood in Stool
Hemorrhoids
Diverticulitis
Heartburn, Indigestion, Reflux

Lactose Intolerant
Peptic Ulcers
Loss of Appetite
Hernia
Gallbladder Problem
Liver Problem(s)
Hepatitis / Jaundice
High Blood Pressure

Heart Murmur
High Cholesterol
Heart Problem(s)_____
Stroke, Mini-Stroke
Chest Pain
Lower Leg Pain

Urine Infections- frequent
Blood in Urine
Painful Urination

Decrease urine flow
Incontinent/Loss of urine
Prostate Problems
Mid Back Pain
Low Back Pain
Shoulder Pain
Hip Pain
Knee Pain
Ankle Pain
Foot Pain
Gout

Kidney Stones

Feet/Ankle/Leg Swelling
Muscle Weakness
Anemia
Bruise- easily
Bleeding Disorder

Depression, Anxiety,
Nervousness
Memory Loss
Moodiness- excess

Bone or Joint Fracture(s)
Arthritis: Osteo or Rheumatoid
Osteopenia or Osteoporosis
Phobias
Mental Illness:_____

Sexual Dysfunction
Menstrual Dysfunction
Urethral Discharge
Vaginal Discharge- abnormal
Venereal Disease(s), STD
Herpes

Neck Pain
Upper Back Pain

Rashes / Hives
Eczema, Psoriasis
Varicose Veins

OTHER:_____
OTHER:_____
OTHER:_____

Please list the reason for today's visit:

1. _____

2. _____

3. _____

Males:
Date of Last PSA (prostate bloodwork): _____ ____Normal ____Abnormal
Date of Last Prostate Exam (rectal): _____ ____Normal ____Abnormal
Other: _____

Females:
Pregnant? ____Yes ____No Planning Pregnancy? ____ Yes ____No
Last Menstrual Period – Date started on: _____
Menstrual Flow: ____Regular ____Irregular ____Pain/Cramps _____Days of Flow
Pain or Bleeding during or after sex? ____Yes ____No
Type of Birth Control: ____Abstinence ____Pills ____Condoms ____Shots ____IUD ____Tubual Ligation
____Hysterectomy _____Other
Number of Children____ Number of Pregnancies____ Abortions____ Miscarriages____ Live Births____
Date of Last Pap Smear or GYN exam: _____ ____Normal ____Abnormal
Date of Last Mammogram: _____ ____Normal ____Abnormal
Menopause __Yes __No, Flushing/Hot Flashes __Yes __No, Hormone Replacement Therapy __Yes __No

Vaccines: (please list date of last)

Flu Vaccine _____ Pneumovax 23 _____ Prevnar _____ Shingles _____
Tetanus _____ Tdap _____ Hepatitis B series _____ Other _____

Date of Last:
Eye Exam _____ ____Normal ____Abnormal Dental Exam _____
Bone Density _____ ____Normal ____Abnormal
Date of Last Colonoscopy: _____ ____Normal ____Abnormal
Date of Last Stool to test for Blood: _____ ____Normal ____Abnormal
Date of Last Urinalysis: _____ ____Normal ____Abnormal
Date of Last time Labs were done: _____ ____Normal ____Abnormal

Surgical History: (please list any Hospitalizations or Surgeries)

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Family History: **F** – Father **M** – Mother **C** – Children **S** – Sister **B** - Brother **FF** – Father's Father **FM** – Father's Mother **MF** – Mother's Father **MM** – Mother's Mother

Alcoholism _____
Asthma _____
Bleeding Disorder _____
Cancer & Type _____
Depression/Anxiety _____
Diabetes _____
Glaucoma _____
Hair Loss _____
Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Mental Illness _____
Migraines _____
Osteoporosis _____
Seizures/Epilepsy/Convulsions_____
Stroke _____
Thyroid Disease _____
Other _____
Other _____
Other_____

Social History: Smoker_____ Former Smoker_____ Never Smoked_____ How many years_____
Cigarettes: ___Yes ___No, How many/much per day_____
Smoke for How Many Years _____ (Age started _____ Age Quit _____)
Tobacco: Dip/Snuff/Chew ___Yes ___No, Amount per day _____ (Age started _____ Age Quit _____)
eCigs or Vaporizors ____Yes ____No Other:_____
Recreational Drug Use ____Yes ____No If Yes, please state type _____
Alcohol: ___Yes ___No Type_____ How Much?_____ How often?_____

Please List All Additional Medical Providers & Approximate Date of When You Last Last Seen Them

Previous Family / Primary Care: _____

Cardiologist (heart, vascular): _____

Pulmonologist (lungs): _____

Gastroenterologist (stomach, colon, liver): _____

Urologist (prostate, bladder, kidney): _____

Neurologist (brain, nerves): _____

Orthopedic (bones & joints): _____

Endocrinologist (diabetes): _____

Dermatologist (skin care): _____

Gynecologist (female care): _____

Nephrologist (renal, kidney): _____

Psychologist (mental disorders): _____

Allergist: _____

Ear, Nose, Throat: _____

Chiropractor: _____

Ophthalmologist (eyes): _____

Pain Management: _____

Physical Therapy: _____

Home Health: _____

Other: _____

*** Pharmacy of Choice: _____ Location _____**

Thank You for Choosing

Lady Lake Family Medicine

Additional Medications Continued:

Medication Name	**Dosage Strength (mg)**	**Directions (take # per day)**	**Prescribed by**
Example: Tylenol	500mg	2 tablets once a day in the mornings	Dr. Who

Dear Patient:
A new requirement for medical practices is to assess your potential risk for falls.
Please complete the following:

FALL RISK ASSESSMENT

Have you fallen in the past year?	YES	NO
Do you lose your balance when standing	YES	NO
Do you lose balance when you initially get up after sitting?	YES	NO
Do you get dizzy, faint or have seizures?	YES	NO
Does it take you more than one try to get up out of a chair or out of bed?	YES	NO
Do you trip over your own feet or objects on the floor?	YES	NO
Do you take corners too sharp; bump into corners or door frames?	YES	NO
Do you use a walker, cane or need assistance to get around?	YES	NO
Do you lose your balance, feel unsteady or stagger when walking?	YES	NO
Have you had a recent loss of or decrease in vision or hearing?	YES	NO
Do you have numbness or loss of sensation in your feet or legs?	YES	NO
Have you experienced a stroke, accident or any other health problems that may have affected your balance?	YES	NO

If you have answered YES to one or more questions, you may have a balance problem. If you are concerned about falling you should speak with your physician.

Patient Name (Printed):_____ DOB:_____

Patient Signature:_____ Date:_____

LADY LAKE FAMILY MEDICINE

John D. Burress, D.O.
Karen Callahan, DNP
Ronald Kope, APRN

PATIENT DEMOGRAPHIC REGISTRATION FORM

Date:_____

PATIENT INFORMATION

Name:_____ _____ _____
LAST FIRST MI

_____ _____
PREFIX SUFFIX (I, II, III, JR, SR, etc.)

Date of Birth: _____ Gender: M F SSN:_____/_____/_____

Marital Status:_____ DL#_____ State _____

Phone (H)_____ Phone (W) _____ Ext_____

Phone (Cell) _____ Email: _____

Address:_____
_____

Zip _____ City_____ State _____

Is this your permanent address? Y N
If no, please indicate permanent address and phone below:

_____
_____
_____

Phone: _____

Person responsible for Account:_____ Relationship:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company:_____
Address:_____ Phone# _____
Policy #_____ Group# _____
Policy Holder _____ Relation to Patient: _____
Policy Holder DOB (if other than patient): _____
Policy Holder Address (if different than patient): _____
_____
Policy Holder Phone # (if different):_____

Patient:_____ DOB_____

ADDITIONAL INSURANCE INFORMATION:

Insurance Company:_____

Address:_____ Phone#_____

Policy #_____ Group#_____

Policy Holder:_____ Relation to Patient_____

Policy Holder DOB (if other than patient):_____

Policy Holder Address (if different than patient):_____
_____

ASSIGNMENT and RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of Insurance Company(s)
_____, and assign directly to Lady Lake Family Medicine, and all its providers, all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above mentioned physicians may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relation

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EMERGENCY CONTACT INFORMATION:

Name:_____ _____
LAST *FIRST*

Phone:_____ _____
HOME OR WORK *CELL*

Relationship: _____

LADY LAKE FAMILY MEDICINE
John D. Burress, D.O.
Karen Callahan, DNP
Ronald Kope, APRN

FINANCIAL POLICY STATEMENTS

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment for your bill is considered part of your treatment. In order to reduce confusion and misunderstanding between you and the practice, we have adopted the following financial policy, which we require you read, agree to, and sign prior to any treatment. If you have any further questions about the policy, please discuss them with our Patient Finance Counselor. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY; THE DOCTOR IS NOT INVOLVED.

- AS A COURTESY, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. IF YOUR INSURANCE COMPANY DOES NOT PAY THE PRACTICE WITHIN 45 DAYS OF FILING, YOU WILL BE RESPONSIBLE FOR FULL PAYMENT.

- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment or coinsurance at the time of service. WE WILL COLLECT THE COPAYMENT OT COINSURANCE WHEN YOU ARRIVE FOR YOUR APPOINTMENT. If your insurance plan denies payment, the remaining balance will be your responsibility.

- If you have insurance coverage with a PLAN THAT WE DO NOT HAVE A PRIOR AGREEMENT , we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. THEREFORE, OUR CHARGES FOR YOUR CARE AND TREATMENT ARE DUE AT THE TIME OF SERVICE.

- Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we will accept CASH, CHECK, VISA, MASTERCARD, DISCOVER and DEBIT CARDS.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a SERVICE or SERVICES ARE NOT COVERED, you will be responsible for the complete charge. PAYMENT IS DUE AT THE TIME OF SERVICE.

- For all services rendered to minor patients, the parent or legal guardian who is accompanying the minor patient is responsible for payment at the time of service.

- Ancillary services provided by this practice (ie: ultrasound, injections, labs) may be subject to additional financial policy statements.

- In order to provide the best possible service and availability to all of our patients, please call us as early as possible if you need to cancel or reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms can be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-Responsible Party

_____

Please print the name of the Patient

LADY LAKE FAMILY MEDICINE

607 Hwy 466
Lady Lake, FL 32159
352-259-7994

PATIENT HIPAA AUTHORIZATION FORM

The Department of Health and Human Services has established a "Privacy & Security Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of all your personal health records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. **When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health information and information about treatment, payment, or healthcare operation in order to provide healthcare that is in your best interest.**

There are times you may wish other family members and friends to inquire about your appointments or have access to your medical information. We will not release any information unless you have listed them below. If you wish to allow messages other than just to return our calls on your voicemail, please indicate this also below.

Voicemail: NO_____ Do not leave message other than to "return call"
YES_____ May leave message regarding medical information

List any family members or others you wish to have access to our records, for example, who may call is regarding your condition or call for you. **WE WILL NOT RELEASE INFORMATION TO SPOUSES OR CHILDREN UNLESS THEY ARE LISTED BELOW.** (We will require signed releases by you for anyone wanting access to your records other than insurance companies you have listed on file, your healthcare provider necessary to your care or persons listed below).

Names authorized (by patient) to receive medical information & their relation to patient:

1. _____ Relation:_____
2. _____ Relation:_____
3. _____ Relation:_____
4. _____ Relation:_____

I, _____also understand I may revoke this authorization at any time, and receive a copy of this authorization.

PRINTED NAME:_____ DATE:_____

SIGNATURE:_____

NO SHOW & CANCELLATION POLICY
for
LADY LAKE FAMILY MEDICINE

Patient Name:_____ Date of Birth:_____

Dear Patient,

Lady Lake Family Medicine has instituted a formal policy regarding cancellations and "no shows". A "no show" is defined as a scheduled appointment that the patient does not keep. To help our patients, we will call to confirm your appointment up to two days before your scheduled appointment. Patients are expected to contact our office no later than twenty-four (24) hours in advance if it is necessary to cancel your appointment so this time can be given to someone who is in need of treatment. Every no-show visit will be recorded in your medical record, and the following administrative fees will be assessed to your account:

First Occurrence: Patient will be sent a letter or called. ***No fine assessed***.

Second Occurrence: Patient will be charged a **$50.00 fee**. (*This fee is the patient's responsibility and is not reimbursable by insurance).*

Third Occurrence: Patient will be charged the full price of the scheduled office visit/procedure. (*This fee is the patient's responsibility and is not reimbursable by insurance).* Patient may be discharged from the practice. The decision whether or not to discharge you will be at your doctor's discretion.

Our aim is to open otherwise unused appointments for our patients, not to collect missed appointment fees. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. We thank you in advance for your cooperation and understanding. By signing below, you acknowledge that you have been presented with the above policy.

_____ _____

Patient Signature Date

_____

Patient Name Printed

_____

Witness

LADY LAKE FAMILY MEDICINE
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of, or read, Lady Lake Family Medicine's
Patient Name

Notice of Privacy Practices containing a description of the uses and disclosures of my health information, certain restrictions on the use and disclosure of my healthcare information and rights I have regarding my protected health information. I further understand that Lady Lake Family Medicine may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy by requesting a current copy.

_____ _____
Signature of Patient Date

_____
Printed Patient Name

If completed by patient's personal representative, please print and sign below.

_____ _____
Printed Patient Personal Representative Name Relation to Patient

_____ _____
Patient Personal Representative Signature Date

Lady Lake Family Medicine
607 Hwy 466
Lady Lake, FL 32159
352-259-7994

Your Information
Your Rights
Our Responsibilities

Your rights-You have the right to:

- ✔ Get a copy of your electronic medical record
- ✔ Correct your electronic medical record
- ✔ Request confidential communication
- ✔ Ask us to limit the information we share
- ✔ Get a list of those with whom we've shared your information
- ✔ Get a copy of this privacy notice
- ✔ File a complaint if you believe your privacy rights have been violated.

Your Choices- You have choices in the way that we use and share information as we:

- ✔ Tell family and friends about your condition
- ✔ Provide disaster relief
- ✔ Include you in a hospital directory
- ✔ Provide mental health care
- ✔ Market our services and sell your information
- ✔ Raise funds

Our Uses and Disclosure- We may use and share your information as we:

- ✔ Treat you
- ✔ Run our organization
- ✔ Bill for your services
- ✔ Help with public health and safety issues
- ✔ Do research

- ✔ Comply with the law
- ✔ Respond to organ and tissue donation requests
- ✔ Work with a medical examiner or funeral director
- ✔ Address workers' compensation, law enforcement, and other government requests
- ✔ Respond to lawsuits and legal action

LADY LAKE FAMILY MEDICINE

John D. Burress, D.O.
Karen Callahan, DNP
Ronald Kope, APRN
607 Highway 466 Lady Lake, FL 32159
352-259-7994 FAX 352-259-7992

REQUEST FOR RELEASE OF MEDICAL INFORMATION

(Make sure all information is complete to prevent a delay in release of information)

Patient's Full Name_____DOB_____

Adress:_____

Phone Number:_____ Last 4 digits of Social Security#_____

This will authorize:

_____
_____ ***to release information to***: **Lady Lake Family Medicine**
_____ **607 Hwy 466**
_____ **Lady Lake, FL 32159**

Purpose for Disclosure:_____
Dates of service to release (FROM):_____(TO):_____

Medical Information Request

€ Complete Records € Radiology Reports
€ Laboratory Reports € Operative Reports/Discharge Summaries
€ Immunization Record €Cardiac Reports
€ Other _____
_____

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorized the release of data and information relating to: **(YOU MUST MARK YES OR NO)**

Yes	**No**	
€	€	1. Substance Abuse (alcohol/drug use)
€	€	2. Mental Health/Depression (includes psychological testing)
€	€	3. HIV-Related Information (AIDS related testing)

I, the undersigned, authorize Lady Lake Family Medicine to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain certain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AID/AIDS-related condition, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes. Release of psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire on year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Lady Lake Family Medicine. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If Authorization is not complete, signed and dated, It may be returned and result in my information not being released until completed.

_____/ _____ _____

Signature of Patient or Legal Guardian Printed Name Date

_____ _____

Relationship (if not patient) Daytime Phone Number Witness

FOR CLINIC USE ONLY

Reviewed and approved by:_____
Records copied and mailed/faxed by:_____