PEDRO R. HERNANDEZ-LATTUF, M.D., P.A.

CARDIOLOGY

PATIENT INFORMATION: **Patient Name**: _____

Please include maiden name, any previous last names used, parent or legal guardian names)

Address_____ **City**_____ **ST**_____ **Zip Code:** _____

Phone **Primary** (_____) _____

Work (_____) _____ **Birthday**_____ **Age**_____

Other/Mobile (_____) _____ **Spouse's Name**_____

Email: _____

Marital Status: (CIRCLE ONE): Single Married Separated Divorced

Widowed:_____ **Race:** _____ **Language:**_____

Emergency Contact _____**Relationship** _____ **Phone #**_____

Patient's Employer/Occupation (If minor, parent/guardian)_____

Pharmacy_____

Location/Address (Street and/or Intersection, City, & State)_____

Who Referred You_____

Family Physician_____**Telephone Number**_____

INSURANCE: Please present your insurance cards, and if the insured is different from the patient, we need the insured's

NAME:_____ **DOB:**_____.

ADDRESS:_____

MEDICAL RECORDS RELEASE FORM: I authorize you to release confidential health information about me, such as: a summary or narrative of my protected health information, tests results, and/or instructions regarding medications, diet, activities, etc, to the person(s). This does not include Physicians or Insurance companies. I understand that this authorization is valid unless I cancel through written notice.

Limitations on the information we may release subject to this Release Form are as follows:

Release my protected health information to the following person(s)/entity: **(This gives us permission to speak with family or friends if you write in their name and relationship.)**

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES: Pedro R. Hernandez-Lattuf, M.D. reserves the right to modify the privacy practices outlined in the notice. I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. We respect the strict confidentiality of the physician-patient relationship. We ask the same of you. By signing below you agree that you will not be recording any person in this facility without their express written consent.

FINANCIAL POLICY: I have reviewed this office's Financial Policy Procedures, which explains how my account will be managed. I understand that I am entitled to receive a copy of this document.

I consent to the release of my protected health information for the purposes of treatment, obtaining payment, and/or supporting the day-to-day health care operations of the practice of Pedro R. Hernandez-Lattuf, M.D.

_____ _____

Signature of Patient or Legal Guardian **Date**

1901 Medi-Park, Suite 138 * Amarillo, Texas 79106 * Telephone (806) 355-3364