Marcos Machado M.D., P.C.
Family Practice Physician

Initial Patient History - Adult

Name: ___________________________________ DOB:___ / ___ / ___ Date: ___ / ___ / ___

Personal Medical History (circle/list conditions you have had or are currently receiving treatment for)

General	**Gastrointestinal**	**Musculoskeletal**	**Respiratory**
Allergies/Hayfever	Chronic abdominal pain	Arthritis	Asthma
	Chronic constipation	Chronic back pain	Blood clot to lungs (PE)
Cardiovascular	Chronic diarrhea	Fractures:______________	COPD / Emphysema
Atrial fibrillation	Diverticulitis / Diverticulosis	Gout	Other:_________________
Congenital heart defect	Gallbladder disease / stone	Joint injury:_____________	
Congestive heart failure	Heartburn/reflux/GERD	Osteoporosis	**Skin**
Heart attack:___________	Hemorrhoids	Other:_________________	Acne
Heart murmur	Hepatitis type:________		Excema
High blood pressure	Hiatal hernia	**Neurologic**	Melanoma
High cholesterol	Liver disease:___________	Meningitis	Other:_________________
Mitral valve prolapse	Ulcerative colitis / Crohn’s	Migraines	
Peripheral vascular disease	Ulcer / GI bleed	Parkinson’s disease	**Females**
Other:_______________	Other:_________________	Polio	Breast mass / biopsies:
		Seizure disorder / Epilepsy	______________________
Endocrine		Stroke / TIA:___________	Chronic pelvic pain
Diabetes	**Hematologic/Oncologic**	Other:_________________	Endometriosis
Hypo / Hyper thyroid	Anemia		Fibroid tumors
Pancreatitis	Blood clots	**Psychiatric**	Hernia
Other:________________	Cancer:________________	ADD / ADHD	Postmenopausal
	Chemotherapy / Radiation	Anxiety	Age started periods: ______
Environmental	G6PD deficiency	Bipolar disease	Age started intercourse:___
Chemical exposure	Sickle cell trait / disease	Depression	# of pregnancies:______
Other:_________________	Other:________________	Schizophrenia	# of deliveries:_______
		Other:_________________	Other:_________________
Eye/Ear/Nose/Throat			
Cataracts	**Infectious Disease**	**Renal/Urinary**	**Males**
Dry Eyes	HIV / Exposure to HIV/AIDS	Bladder tumor	Enlarged prostate
Glaucoma	TB / Exposure to TB	Bladder stones	Erectile Dysfunction
Hearing loss	Other:_________________	Chronic kidney disease	Hernia
Macular Degeneration		Dialysis	Prostate cancer
TMJ disorder		Kidney stones	Other:_________________
Other:_________________		Other:_________________	

Medications Name/Dose/Directions	**Medication Allergies** Drug/Reaction	**Surgeries** Procedure/Year

MARCOS MACHADO M.D., P.C.
FAMILY PRACTICE PHYSICIAN

Name: ___________________________________DOB:___ / ___ / ___ Date: ___ / ___ / ___

Family History (please fill in, and √ your responses)

	Father	Mother	Siblings	Children	Grandparents	Comments
Alcoholism	_	_	_	_	_	____________________
Allergies/hayfever	_	_	_	_	_	____________________
Arthritis	_	_	_	_	_	____________________
Anemia	_	_	_	_	_	____________________
Asthma	_	_	_	_	_	____________________
Bleeding disorder	_	_	_	_	_	____________________
Cancer (type)	_____	_____	_____	_____	_____	____________________
Ulcerative Colitis	_	_	_	_	_	____________________
Crohns disease	_	_	_	_	_	____________________
Diabetes	_	_	_	_	_	____________________
Drug abuse	_	_	_	_	_	____________________
Seizure disorder	_	_	_	_	_	____________________
Glaucoma	_	_	_	_	_	____________________
Heart attack/disease (age)	____	____	____	____	____	____________________
Hepatitis	_	_	_	_	_	____________________
High blood pressure	_	_	_	_	_	____________________
High cholesterol	_	_	_	_	_	____________________
Kidney disease	_	_	_	_	_	____________________
Migraines	_	_	_	_	_	____________________
Osteoporosis	_	_	_	_	_	____________________
Psychological disorder (type)	_____	_____	_____	_____	_____	____________________
Skin disease (type)	_____	_____	_____	_____	_____	____________________
Stroke (age)	____	____	____	____	____	____________________
Thyroid disease	_	_	_	_	_	____________________
Ulcers	_	_	_	_	_	____________________
Other:	_____	_____	_____	_____	_____	____________________
	_____	_____	_____	_____	_____	____________________

Social History (please circle, fill in, and √ your responses)

__ I have never used tobacco - or - __ I used to use tobacco but quit in _____ (which year?). – or -

__ I currently use tobacco: dip / vape / smoke ___ cigarette / packs per day and have for ___ years

__ I do not drink alcohol – or - __ I drink ___ drinks every [day / week / month / socially.] Usually [beer / wine / liquor].

__ I do not use illegal drugs

__ Illegal drugs I currently use _____________________. Drugs I used to use ________________________________.

I am [working / unemployed / retired / stay at home]. My current or previous employment: ______________________

I am [single / married / widowed / living with significant other]. __ I have been or was married since ______.

I live in a [house / apartment / modular home] with (circle): spouse, __children, mother, father, __ siblings, ___ pets

__ I do not exercise – or - __ I do exercise for ___ minutes each week.

Screening and Prevention

Last Mammogram: _________ Any abnormalities in the past? ____

Last Pap Smear: ________ Any abnormalities in the past? ____

Last Colonoscopy: ________, next colonoscopy is due in __________ Last Cologuard:________

Tetanus shot:_____________ Pneumonia shot:__________ Shingles shot:____________ Flu shot:__________

Marcos Machado M.D., P.C.
Family Practice Physician

Name: ___________________________________DOB:___ / ___ / ___ Date: ___ / ___ / ___

What is your main concern today? ____

____

____

Do you have any other concerns? _Yes (please list) _No ____________________________________

____

____

Current Review of Systems (circle/list symptoms you currently have in relation to your main concern)

Constitutional symptoms: fever, weight loss, weight gain, extreme fatigue

Eyes: double vision, sudden loss of vision, blurred vision

Ear, nose and throat: sore throat, congestion, runny nose, ear pain, ringing in ears

Cardiovascular: chest pain, heart racing sensation, swelling

Respiratory: cough, wheezing, shortness of breath

Gastrointestinal: nausea, vomiting, abdominal pain, constipation, diarrhea, blood in stools, jaundice

Genitourinary: discharge, freq urination, painful urination, bloody urine, irregular periods, impotence, poor urine stream

Skin: acne, rash, changing mole, sore or ulcer

Neurological: headache, weakness, numbness or tingling, falling, dizziness, vertigo

Musculoskeletal: joint pain, joint swelling, muscle weakness, muscle aches

Psychiatric: depression, anxiety, suicidal thoughts

Endocrine: excessive thirst, cold or heat intolerance

Hematologic: unusual bruising or bleeding, enlarged lymph nodes

Women: First day of your last menstrual period:_________

Other: ____

Pharmacy (please include city/cross street information):__________________________________

Patient Signature:_____________________________ Date:___/___/___ Reviewed:___________________________

MARCOS MACHADO M.D., P.C.
FAMILY PRACTICE PHYSICIAN

Patient Information Form

Patient Name ____ Soc. Security # _______________ DOB ___________

Address ____________________________________ City ______________ Zip ______ Primary Phone (____)___________

Sex: ☐ M ☐F Marital Status: ☐M ☐S ☐W ☐D Additional Phone (____)__________

Race: _________________ ☐Decline Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Decline

Employer _________________________ Employer Address ____

Spouse's Name _____________________ Soc. Security # _______________ Spouse's Employer ________________

Spouse's Employer address ____Employer Phone ____________

~~~~~~

Person responsible (if a minor)
Name _______________________________________ Relationship _______________ Primary Phone (____)___________

Address ____________________________________ City ______________ Zip ______ Additional Phone (____)___________

Employer Name _________________________________ Employer Phone _________________________________

Employer Address ____

~~~~~~

Primary Health
Insurance Name ________________________ Contract # _________________ Group# __________________

Subscriber Name_____________________DOB_______ Address ____

Secondary Health
Insurance Name ________________________ Contract # _________________ Group# ____________

Subscriber Name_____________________DOB_______ Address ____
OTHER COVERAGE:____

~~~~~~

Name of Emergency Contact: ____ Relationship ____________

Address __________________________________ Home Phone (_____)____________ Work Phone (_____)________________

Second Emergency Contact: ____ Relationship ____________

Address __________________________________ Home Phone (_____)____________ Work Phone (_____)________________

Do you have an Advance Directive? Yes __ No __ Do you have an authorized Power of Attorney? Yes __ No __

(Please give us a copy to scan into your chart.)

Please list all physicians you see:____
Please list household members: ____

Signature: ____ Date: _____________
~~~~~~

MARCOS MACHADO M.D., P.C.
FAMILY PRACTICE PHYSICIAN

Office Policies

Referral Process
It may be necessary for our office to refer you to a specialist to manage your care. In order for a referral to be made, you must be evaluated first in our office. I only refer to the Preferred Panel of specialists from Genesys Regional Medical Center. If you need to request a referral from us, phone us at least one week prior to your appointment. As part of the referral process, we may need to share your medical information with another provider or specialist. Your privacy is protected as only minimal information is shared.

Medication Refills
Please bring your medications to your appointments. Should you need refills prior to your next appointment, first call your pharmacy. They can request the refill from our office. Please give us at least 48 hour notice prior to your medication running out, 2 weeks notice if it's a mail-order pharmacy. Pain medicines may require an appointment.

Billing
Please bring your insurance card to each visit. All co-pays and deductibles are the patient's responsibility and expected to be paid on the day of service.

Scheduling Appointments
Patients are seen by appointment only, except in the case of an emergency, which may cause delays. We ask your understanding, knowing that if you ever require urgent care, we will give you prompt attention. To schedule appointments, please call (810) 635-4476. In the event that you are unable to keep your appointment time, please call at least 24 hours in advance to reschedule. **There will be a $25 charge for no show appointments**. If you miss 3 or more appointments due to a "no show" appointment, your chart will be reviewed and you may be discharged from this practice.

Hospital/Emergencies
I have admitting privileges at Genesys Regional Medical Center. If you have a life-threatening illness, call 911 or go to the Genesys Emergency Room and have a family member call our office.

After Hours/On Call Policy

Please call the main office phone (810-635-4476) if you need medical attention that cannot wait until morning. You will be connected to the answering service. Please leave your name and number where you can be reached with the answering service. After speaking with you, you may be prescribed medication, advised to follow up in the office, or advised to pursue further urgent or emergent care.

Genesys After Hours North
4154 W. Vienna Road
Clio, MI 48420
(810) 686-7397

Genesys After Hours South
8447 Holly Road, Suite A
Grand Blanc, MI 48439
(810) 603-0856

Genesys Urgent Care
1460 Center Rd
Burton, MI 48509
(810) 715-4620

Signature: ____ Date: ____/____/____

Please read and sign the following statements:

I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered to my or my dependant. I understand I am responsible for any amount not covered by insurance.

Signature: ____ Date: ____/____/____

Responsible Party's Signature: ____ Date: ____/____/____

Medicare One Time Direction of Payments

I give my permission to ask for Medicare payments for my medical care. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Health Care Financing Administration (HCFA) is the government Medicare agency.

Medicare Beneficiary Signature: ____ Date: ____/____/____

Notice of Privacy Practices Acknowledgement

I, the undersigned, acknowledge receipt of the Notice of Privacy Practices.

____ Date: ____/____/____
Signature of patient or personal representative

If Personal Representative's signature appears above, please describe the Personal Representative's relationship to the patient.

____

MARCOS MACHADO M.D., P.C.
FAMILY PRACTICE PHYSICIAN

NOTICE OF PRIVACY PRACTICES (Effective Date:9/20/2013)

Marcos Machado M.D., P.C. 10019 Miller Road, Swartz Creek, MI 48473(P)810.635.4476 (F) 810.635.4357

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our office.

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in on a computer in an electronic health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide, or with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die. 2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may disclose information to other healthcare providers to assist them in obtaining payment for services they have provided to you. 3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. The list of OHCAs we participate in is available from the office staff. 4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. 5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may call out your name when we are ready to see you. 6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others. 7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization. 8. Sale of Health Information. We will not sell your health information without your prior written consent. The consent will disclose that we will receive compensation for your health information if you allow us to sell it, and we will stop any future sale of your information to the extent that you revoke that consent. 9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect, domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. 10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm. 11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law. 12. Judicial and Administrative Proceedings.We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order. 13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to law enforcement for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. 14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths. 15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues. 16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public. 17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent. 18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody. 19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer. 20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another doctor or group. 21. Breach Notification. In the case of a

breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses/disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use/disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items/services for which you paid for in full yourself, we will abide by your request, unless we must disclose the info for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision. 2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. 3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. 4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information. 5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities. 6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our office at 8106354476.

Changes to this Notice of Privacy Practices - We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website, www.machadomd.com.

Complaints - Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint either through the regional Office of Civil Rights (address found at http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html) or email OCRMail@hhs.gov. The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Release of Information Authorization Form

I, ___________________________________ hereby authorize Dr. Machado and his employees and agents, to release to
(patient name)

____

____
(names of representatives)

my personal health information maintained in this physician's office, as it relates to the diagnosis, treatment, claims payment, appointments, and health care services provided or to be provided to me, including al which identifies my name, address, social security number, and insurance numbers.

Information NOT to be shared/disclosed, if any, is as follows: (If nothing please indicated N/A)

____

____

This authorization is valid from the date of my signature below, and shall expire upon my **written** desire to revoke authorization of the the release of this information to my current, chosen representative.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to receive evaluation, treatment, referrals, hospitalizations, or any other medical activity with this physician and/or, his office personnel.

____ ____________________
(patient signature) (date of signature)