Patient Identification Area

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CONSENT FOR AUDIO-RECORDING OF VISIT FOR SCRIBE PURPOSES

A. PATIENT INFORMATION

Imprint Patient Name, MR#., D.O.B.

B. PERMISSION TO RECORD

I give my permission to audio-record my examination/treatment visits with my provider (doctor, nurse practitioner, etc.).

The reason for recording my visits is to allow a medical documentation expert to review my provider/patient visits, and then help my provider create a written summary of the visits for my patient record. After a recording has been turned into a written chart note, the recording will be destroyed.

C. I UNDERSTAND AND AGREE THAT

- Giving permission to audio-record my visits is voluntary.
- My examination, treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I say "No" and do not sign this consent form.
- I can ask my provider to stop or pause the recording at any time.
- My written consent to audio-record my clinic visits expires 12 months from today's date.
- I will be asked to give verbal permission to audio-record at each future visit during the next 12 months, and I can say "No" each time.
- My questions about this process and this consent form have been answered.

D. SIGNATURE AND DATE

Patient's Signature: _____ **Date:** _____

Print Name: _____

When Patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship to patient:** _____

Signature of Witness: _____ **Date:** _____

Print Name: _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

LEONARD A. SUKIENIK D.O. PA is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other
☐ Spouse (provide name & phone number) _____	☐ Financial ☐ Medical as follows: _____
☐ Parent (provide name & phone number) _____	☐ Financial ☐ Medical as follows: _____
☐ Other (provide name & phone number _____	☐ Financial ☐ Medical as follows _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised January 2010

Primary Care West Palm Beach

IF YOU HAVE FILLED THIS OUT WITHIN THE LAST 12 MONTHS AND HAVE NO NEW CANCERS TO REPORT CHECK HERE AND STOP FILLING OUT FORM: ☐

Patient Name:_____

Date Birth _____Provider: _____Today's Date:_____

This is a screening tool for cancers that run in families. Answer **YES or NO.**

If any YES please **LIST** relatives with cancer diagnoses on your **MOTHER's (M) and FATHER's (P) Side** for these relatives only: **Parents, Siblings, Children, Aunts/Uncles, Grandparents, Nieces/Nephews**

Please circle YES or NO			**Specify Relative(s) or Self**	**Specify Cancer**	**Age of Diagnosis**
Y	N	Breast Cancer diagnosed at age 49 or under			
Y	N	Ovarian Cancer at any age			
Y	N	Three Breast Cancers on the same side of family (any age)			
Y	N	Male Breast Cancer (any age)			
Y	N	Colon or Endometrial Cancer in YOURSELF age 49 or under			
Y	N	Three of the following Cancers on the same side of the family: COLON / UTERINE OVARIAN / GASTRIC			
Y	N	Ashkenazi Jewish Ancestry with a BREAST, OVARIAN or PANCREATIC Cancer at any age			
Y	N	Please List ALL Other Cancers:			
Y	N	Ashkenazi Jewish Ancestry			

FOR OFFICE USE ONLY

☐ Patient is NOT appropriate for genetic testing
☐ Patient IS appropriate for genetic testing
☐ Patient offered genetic testing: Accepted OR Declined

HCP Signature: _____Patient Signature: _____