NOTICE OF PRIVACY PRACTICES

Jacksonville Hearing & Balance Institute At Center One

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

At North Florida Surgeons, P.A. ("North Florida"), we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices ("Notice") describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit North Florida; a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information may be used or disclosed to:

- Plan your care and treatment.
- Communicate with other providers who contribute to your care.
- Serve as a legal document.
- Receive payment from you, your plan, or your health insurer.
- Assess and continually work to improve the care we render and the outcomes we achieve.
- Comply with state and federal laws that require us to disclose your health information.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of North Florida, the information belongs to you. You have the right to request to:

- Access, inspect and copy your health record. North Florida will charge you a reasonable cost-based fee for the cost of supplies and labor of copying.
- Amend your health record which you believe is not correct or complete. North Florida is not required to agree to the amendment if North Florida did not create the information or if it is correct or complete.
- Obtain an accounting of disclosures of your health information.
- Communications of your health information by alternative means (e.g. e-mail) or at alternative locations (e.g. post office box).
- Place a restriction to certain uses and disclosures of your information. In most cases North Florida is not required to agree to these additional restrictions, but if North Florida does, North Florida will abide by the agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). North Florida must comply with a request to restrict the disclosure of protected health information to a health plan for purposes of carrying out payment or health care operations if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Obtain a copy of your health care information in paper or electronic format.

Our Responsibilities

North Florida is required to:
- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.

- Abide by the terms of the Notice currently in effect
- Notify you in writing if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Notify you in writing of a breach where your unsecured health information has been accessed, acquired, used or disclosed to an unauthorized person.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, such revised Notices will be made available to you.

We will not use or disclose your health information without your written authorization, except as described in this Notice.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact:

Privacy Officer
North Florida Surgeons, P.A.
11945 San Jose Boulevard
Building 300
Jacksonville, FL 32223
Telephone: (904) 396-1725

If you believe your privacy rights have been violated, you can file a written complaint with North Florida's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the address. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

Treatment: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your medical record and used to determine the course of treatment that should work best for you. To promote quality care, North Florida operates an electronic medical record called the "EMR". This is an electronic system that keeps health information about you.

North Florida may also provide a subsequent healthcare provider with health information about you (e.g., copies of various reports) that should assist him or her in treating you in the future. North Florida may also disclose health information about you to, and obtain your health information from, electronic health information networks in which community healthcare providers may participate to facilitate the provision of care to patients such as yourself.

North Florida may use a prescription hub which provides electronic access to your medication history. This will assist North Florida health care providers in understanding what other medications may have been prescribed for you by other providers.

Payment: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, diagnosis, procedures, and supplies used.

Health Care Operations: We may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: We may contract with third parties to provide services on our behalf and disclose your health information to our business associate so that they can perform the job we've asked them to do. We require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication from Offices: We may call your home or other designated location and leave a message on voice mail, in person, or by text, in reference to any items that assist North Florida in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to

your home or other designated location any items that assist North Florida in carrying out Treatment, Payment and Health Care Operations, such as appointment reminders, patient satisfaction surveys and patient statements.

Communication with Family/Personal Friends: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. When a family member(s) or a friend(s) accompany the patient into the exam room, it is considered implied consent that a disclosure of the patient medical data is acceptable.

To Avert a Serious Threat to Health or Safety: We may use your health information or share it with others when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information. Under no circumstances, however, would we allow researchers to use your name or identify you publicly.

Coroners, Medical Examiners and Funeral Director: In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors as necessary to carry out their duties

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations, federally funded registries, or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you by mail, e-mail or text to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to opt-out by notifying us in writing.

Fund Raising: We may contact you as part of a fund-raising effort. You have the right to opt-out of receiving such information by notifying us in writing.

Health Oversight Activities: We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs, such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law.

Inmates and Correctional Institutions: If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers if necessary to provide you with health care, or to maintain safety at the place where you are confined.

Lawsuits and Disputes: We may disclose your health information if we are ordered to do so by a court that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure.

As Required by Law: We may use or disclose your health information if we are required by law to do so.

Revised October 31, 2012

PATIENT REGISTRATION

Jacksonville Hearing & Balance Institute At Center One

PATIENT NAME (FIRST, MIDDLE, LAST)		**DATE OF BIRTH**			
SOCIAL SECURITY NUMBER		**GENDER**	☐ Male ☐ Female		
RESPONSIBLE PARTY'S NAME (if other than patient)					
HOME ADDRESS		**APT NUMBER**			
CITY		**STATE**		**ZIP**	
HOME PHONE	( ) -	**CELL PHONE**	( ) -		
EMAIL ADDRESS		**PREFERRED CONTACT**	☐Home Phone ☐Cell Phone ☐Email		
MARITAL STATUS	☐ Single ☐ Married ☐ Widowed ☐ Divorced	**LANGUAGE**	☐ English ☐ Other:		
RACE	☐ White ☐ Black ☐ Asian/Pacific Islander ☐ Hispanic ☐ American Indian ☐ Other ☐ Do not wish to respond				
ETHNICITY	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Do not wish to respond				
EMERGENCY CONTACT NAME		**PHONE NUMBER**	( ) -		
EMPLOYER NAME		**WORK NUMBER**	( ) -		
PRIMARY INSURANCE		**POLICY NUMBER**			
POLICY HOLDER'S NAME		**POLICY HOLDER'S DATE OF BIRTH**			
SECONDARY INSURANCE		**POLICY NUMBER**			
POLICY HOLDER'S NAME		**POLICY HOLDER'S DATE OF BIRTH**			
IS THIS APPOINTMENT RELATED TO AN AUTO-ACCIDENT OR WORK-RELATED INJURY?			☐ Yes ☐ No		
IF YES, WHAT WAS THE DATE OF INJURY?					
LEGAL GUARDIAN, SPOUSE, PARENT OR POWER OF ATTORNEY INFORMATION					
FULL NAME		**RELATIONSHIP TO PATIENT**			
PHONE NUMBER	( ) -	**DATE OF BIRTH**			
HOME ADDRESS		**APT NUMBER**			
CITY		**STATE**		**ZIP**	
ADDITIONAL INFORMATION					
HOW DID YOU HEAR ABOUT US?					
REFERRING PHYSICIAN		**PRIMARY CARE PHYSICIAN (PCP)**			
WHAT PHARMACY DO YOU USE?		**PHONE NUMBER**	( ) -		
PHARMACY ADDRESS/STREET					
DO YOU HAVE A LIVING WILL?	☐ Yes ☐ No				
I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.					
PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					

Jacksonville Hearing & Balance Institute (JHBI) is a part of North Florida Surgeons (NFS)

NORTH FLORIDA surgeons

PATIENT REGISTRATION CONTINUED

Jacksonville Hearing & Balance Institute At Center One

PRIVACY NOTICE ACKNOWLEDGMENT
I acknowledge that I have received a copy of **Jacksonville Hearing and Balance Institute "JHBI"/North Florida Surgeons "NFS"** privacy notice. I understand that I am responsible to read this notice and notify **JHBI/NFS**, in writing, of any request for restrictions in the use or disclosure of my individually identifiable health information. **JHBI/NFS** has the right to revise this notice at anytime and will post a copy of the current notice in the office in a visible location at all times. **JHBI/NFS** will provide me with a copy of its most recent notice upon my request.

EMAIL CONSENT
I acknowledge that I have received and read a copy of the **JHBI/NFS** E-mail consent (available upon request). I understand that if I want to correspond by email that I must agree to the terms of the E-mail consent, check the appropriate box. ☐ **I WANT** to correspond by email. I understand the risks associated with the communication of email between the practice and me. I consent to the conditions outlined in the E-mail consent. Any questions I may have had were answered to my satisfaction. ☐ **I DO NOT** want to correspond with the practice by E-mail.

RECORDS RELEASE
I hereby authorize **JHBI/NFS**, and its agents, to release all medical records concerning my treatment as requested by other physicians or hospitals to said physicians or hospitals.

AUTHORIZATION FOR VERBAL RELEASE OF MEDICAL INFORMATION
I hereby authorize **JHBI/NFS** to discuss my medical, payment, scheduling, and healthcare information pertaining to my treatment and care to the following individuals:

FULL NAME		**RELATIONSHIP TO PATIENT**	
FULL NAME		**RELATIONSHIP TO PATIENT**	
FULL NAME		**RELATIONSHIP TO PATIENT**	
FULL NAME		**RELATIONSHIP TO PATIENT**	

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED ON THIS PAGE.					
PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					
RELATIONSHIP TO PATIENT		***FRONT OFFICE INITALS***			

FINANCIAL AGREEMENT

Jacksonville Hearing & Balance Institute At Center One

PATIENT NAME		DATE OF BIRTH			

FINANCIAL RESPONSIBILITY

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at **Jacksonville Hearing and Balance Institute "JHBI"/North Florida Surgeons "NFS"**. I am responsible for any applicable deductible or co-payments prior to the provision of services. **JHBI/NFS** will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance. I further understand that such payment is not contingent on any insurance, settlement or judgment payment. **JHBI/NFS** may file a claim for payment with my insurance company as a courtesy to me. If the insurance company fails to pay **JHBI/NFS** in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **JHBI/NFS**. Should the account be referred to a collection agency or attorney for collection, the undersigned agrees to pay the collection agency's fee (based on a percentage of your account balance, the current percentage is 33%) and all costs of collection, including a reasonable attorney's fee.

RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE AND OBTAIN REFERRAL

I understand that it is my responsibility to provide **JHBI/NFS** with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). **JHBI/NFS** is not obligated to see patients without a valid referral. If I do not have insurance, I will be considered a Private Pay patient and be financially responsible for the total amount of the services provided. I will notify **JHBI/NFS** immediately upon any change in my insurance.

INSURANCE WAIVER

I understand that if I do not have a copy of a current insurance card and valid referral, if required, that I can be seen as a "Private Pay" patient. I agree that neither **JHBI/NFS** nor I will file a claim for the visit. A waiver will be completed for each visit that I am seen as a Private Pay patient. I will be required to pay the total cost of the visit in advance.

Please be aware that when we verify your benefits, your healthcare insurance company discloses to us that verification of benefits is not a guarantee for payment. Payment will be finalized according to your plan's benefits when your healthcare insurance company receives and processes the claim.

ASSIGNMENT OF BENEFITS

I hereby authorize and assign all payments and/or insurance benefits for medical services and/or surgical procedures rendered to patient, directly to **JHBI/NFS**. I hereby authorize **JHBI/NFS** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by my insurance plan.

ASSIGNMENT OF MEDICARE BENEFITS

I hereby authorize and assign all payments of authorized Medicare benefits for medical services and/or surgical procedures rendered to patient, directly to **JHBI/NFS**. I hereby authorize **JHBI/NFS** to release medical information necessary to obtain payment. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an ABN.

LEGAL/DISABILITY FORMS AND LETTERS

I understand that LEGAL/DISABILITY FORMS which need completion by a Physician require a pre-paid fee of **$25.00**. The expected fee for a written letter by a Physician is **$125.00**. Once payment has been received please allow 10 business days for completion of documents requested.

BY SIGNING THIS FINANCIAL AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED ON THIS FINANCIAL AGREEMENT PAGE.

PATIENT SIGNATURE		TODAY'S DATE			

FINANCIAL AGREEMENT CONTINUED

Jacksonville Hearing & Balance Institute At Center One

ARBITRATION AGREEMENT

THIS ARBITRATION AGREEMENT is made between **North Florida Surgeons, P.A**., for and on behalf of itself and its subsidiaries, affiliated professional associations, physicians (including physicians providing medical services through a subsidiary of North Florida Surgeons, P.A.), agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and the above referenced patient ("Patient"). It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but also their heirs, personal representatives, guardians and any persons deriving claims through or on behalf of the patient.

It is understood by the Patient that he or she is not required to use **North Florida Surgeons, P.A**. or any Doctor and that there are numerous other physicians located near Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Other than what may be in conflict with this Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and the Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only.

Prior to commencing any action under this Arbitration Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by the filing of an application for arbitration within the applicable statute of limitations for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following Florida counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Duval County, Florida.

In the event that either party to this Arbitration Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrators shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

Except for legal reporting requirements, all arbitration proceedings and outcomes under this Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Duval County, Florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." The Patient understands and acknowledges that signing this Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, the sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patient has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had this Arbitration Agreement translated for him or her by _____. The Patient has had an opportunity to ask questions about this Arbitration Agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with an attorney before signing this Arbitration Agreement.

BY SIGNING THIS ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS.

PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					
WITNESS SIGNATURE		***PHYSICIAN SIGNATURE***			

PATIENT MEDICAL HISTORY

Jacksonville Hearing & Balance Institute At Center One

PATIENT NAME		DATE OF BIRTH			
CHIEF COMPLAINT (Reason for your visit)					

PAST MEDICAL HISTORY (Check if you have ever been diagnosed with the following)

☐ Allergies	☐ Cancer/Tumors	☐ Liver Disease	☐ Migraine Headaches
☐ Anemia/Bleeding Disorder	☐ Depression	☐ High Blood Pressure	☐ Seizures/Epilepsy
☐ Anxiety	☐ Diabetes	☐ Hearing Loss	☐ Sickle Cell Disease
☐ Arthritis	☐ Ear Infections	☐ Immunodeficiency	☐ Stroke
☐ Asthma/Chronic Lung Disease	☐ Glaucoma	☐ Kidney Disease	☐ Thyroid Disease
☐ Other (please list):			
☐ **NONE OF THESE APPLY**			

SURGICAL HISTORY (Be sure to include prior ear surgeries)

Type of Surgery	Surgery Date	Type of Surgery	Surgery Date

What is your reaction to anesthesia?	☐ No Reaction ☐ Difficulty Breathing ☐ Difficulty Waking ☐ Other:

FAMILY MEDICAL HISTORY (Check all that apply to any family member(s))

☐ Autoimmune Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Cancer (list):	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Diabetes	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Hearing Loss	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Lung Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Sickle Cell Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Stroke	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Thyroid Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ Other (list):	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Grandparent
☐ **NO RELEVANT FAMILY HISTORY**					

SOCIAL HISTORY

Occupation					
Alcohol Consumption	☐ None ☐ Daily ☐ Weekly ☐ Occasionally ☐ Socially				
Tobacco Use	☐ Never ☐ Former ☐ Current	**Type**	☐ Cigarettes ☐ Pipe ☐ Chew ☐ Smokeless ☐ Snuff		
How many packs a day?		**When did you quit?**		**How many years did you smoke?**	
Drug Use	☐ None ☐ Marijuana ☐ Cocaine ☐ Crack ☐ Heroin ☐ Other:				

PATIENT MEDICAL HISTORY CONTINUED

Jacksonville Hearing & Balance Institute At Center One

CURRENT MEDICATIONS (Include insulin, steroids, inhalers, oxygen, eye drops, etc) ☐ **LIST ATTACHED**		
Medication Name	**Strength**	**Frequency**
EXAMPLE: AMOXICILLIN	*500MG*	*THREE TIMES A DAY*
☐ **NO CURRENT MEDICATIONS**		

ALLERGIES AND ADVERSE REACTIONS (Include allergies to antibiotics, latex, dye, pain medications if applicable)
☐ **NO KNOWN ALLERGIES**

REVIEW OF SYSTEMS (Check all conditions that **CURRENTLY** apply)	
Constitutional	☐ Chills ☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Night Sweats
HEENT (Head, Eyes, Ears, Nose, Throat)	☐ Double Vision ☐ Dizziness ☐ Dysphagia (difficulty swallowing) ☐ Ear Drainage ☐ Hoarseness ☐ Lump in throat ☐ Visual Changes ☐ Hearing Loss
Respiratory	☐ Shortness of Breath ☐ Wheezing
Cardiovascular	☐ Chest Pain ☐ Heart Murmur ☐ Palpitations
Gastrointestinal	☐ Abdominal Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Vomiting
Genitourinary	☐ Dysuria (Pain while urinating)
Hematologic	☐ Easy Bruising ☐ Easy Bleeding
Metabolic/Endocrine	☐ Heat intolerance ☐ Cold intolerance ☐ Increased Thirst
Neurological	☐ Difficulty falling asleep ☐ Numbness in extremities ☐ Syncope ☐ Tingling ☐ Tremor ☐ Weakness
Psychiatric	☐ Anxiety ☐ Depression ☐ Hallucinations
Other (please list):	
☐ **NONE OF THESE APPLY**	

I CERTIFY THAT I HAVE DISCLOSED ALL OF MY MEDICAL HISTORY KNOWN TO ME. I ACKNOWLEDGE THAT I AM RESPONSIBLE TO MAKE YOUR OFFICE AWARE OF ANY CHANGES TO MY MEDICAL HEALTH.

PATIENT SIGNATURE		**TODAY'S DATE**			
PARENT, GARDIAN OR LEGAL REPRESENTATIVE SIGNATURE					
RELATIONSHIP TO PATIENT		***PROVIDER SIGNATURE***			

REQUEST FOR MEDICAL RECORDS RELEASE

Jacksonville Hearing & Balance Institute At Center One

REQUEST FOR RECORDS			
PATIENT NAME		DATE OF BIRTH	
PHYSICIAN/FACILITY			
ADDRESS			
FAX NUMBER			

TYPE OF MEDICAL RECORDS REQUESTED

☐ IMAGING: Please send **ANY** MRI/CT of head or brain on **DISK WITH REPORT**

☐ PHYSICIANS: Please send RECORDS including any **AUDIO AND BALANCE TESTING REPORTS**

☐ OTHER:_____

RECORDS RETURN

PLEASE RETURN ATTENTION	

JACKSONVILLE HEARING AND BALANCE INSITIUTE
10475 Centurion Parkway North, Suite 303
Jacksonville, FL 32256
P: 904-399-0350
F: 904-399-5914

I HEARBY AUTHORIZE YOU, THE PHYSICIAN OR HOSPITAL NAMED ABOVE, TO RELEASE MY COMPLETE MEDICAL RECORDS TO JACKSONVILLE HEARING AND BALANCE INSTITUTE.

PATIENT SIGNATURE		TODAY'S DATE	