

Dennis L. Fernandez, M.D., F.A.C.S.

Patient Information

Patient's Name _____
Last Name First Name Middle Name

Date of Birth _____

As a result of the healthcare bill that was passed into law by Congress in 2010 (Patient Protection and Affordable Care Act), we are *legally required* to ask *all patients* the following questions. However, *you are not required* to give the requested information. If you choose not to provide the information, please check the “decline to answer” box.

What is your preferred language?

- English
- French
- Greek
- Italian
- Japanese
- Portuguese
- Russian
- Spanish
- Decline to answer

Which one best describes your Ethnicity?

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown
- Decline to answer

What is your Race?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Unknown
- Decline to answer

Patient Signature: _____ **Date:** _____

DENNIS L. FERNANDEZ, M.D., P.C.
Dennis L. Fernandez, M.D., F.A.C.S.
General Surgery

4025 Pepperwood Circle SW, Suite C
Huntsville, AL 35801
Office: (256) 882-1908 • Fax: (256) 882-1907

Due to Federal Privacy Laws relating to the new HIPAA regulations we are unable to provide information to *anyone except you*, the patient regarding medical conditions, prescriptions, appointment times or any other information held by the practice *without your specific permission*.

If you desire your spouse, friends, parent, sister or brother or any other designated person to pick up prescriptions, make or check appointments, receive laboratory results or discuss your private medical information, please list that person's name below and sign and date this authorization.

I, _____ Date of Birth _____

hereby authorize Dennis L. Fernandez, M.D., P.C. to release information from my medical records to include, but not limited to my complete medical record, prescription information, appointment or visit information, x-ray results, tests and test results, and laboratory results to the person/persons noted below.

I understand that this consent may be revoked at any time to the extent that disclosure made in good faith has already occurred in release of information on this consent.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

FOR TRANSFER OF MEDICAL RECORDS

I authorize Dennis L. Fernandez, M.D., P.C. and associated personnel to release my medical information to the following:

Name of Physician _____

Name of Physician _____

Name of Physician _____

Patient Signature _____ Date _____

Dennis L. Fernandez, M.D., P.C. employees and officers, and attending physicians are released from legal responsibility or liability for release of the above noted information to the extent authorized herein.

Patient's Signature _____ Date _____

If not signed by patient, relationship to patient _____

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PRESCRIPTION REFILL POLICY

Please read the following prescription refill policy carefully and sign below.

1. I agree to allow 48 hours for prescription refills.
2. I understand that prescription refills requested after 3:00 p.m. will not be received until the next day.
3. I understand that a follow up visit may be required from my physician in order to obtain a refill.
4. I agree to take all medication exactly as instructed. I may not change the dosage or alter the time to take the medication without first speaking to my physician.
5. I must keep all appointments as recommended, so that prescription medications can be monitored.
6. I will not give, trade, or sell medication.
7. I will not alter or forge a prescription. This is a felony and will be reported.
8. I will not combine any narcotic medications with the consumption of alcohol.

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe pain medications to me.

Patient's Name _____

Date _____

Signature _____

My pharmacy's information is:

Name _____

Location _____

Phone () _____

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I have received the “Notice of Privacy Practices” and give my permission to Dennis L. Fernandez, M.D., P.C. to use and disclose my health information in accordance with the notice provided.

Patient’s Name _____

Signature _____

Date _____

If not signed by patient, name and relationship to patient: _____