Marizeli Olacio, DPM, AACFAS

Omega Medical Group
1400 NE Miami Gardens Drive, Suite 104
North Miami Beach, FL 33179
305.514.0404

Shores Family Doctors
9838 NE 2nd Ave
Miami Shores, FL 33138
305.758.7878

Authorization and Request of Release of Medical Records

Date:_____

Patients Name:_____

SS#_____ DOB:_____

Holder of medical records: _____

I hereby request and authorize the above mentioned holder to release the following information, as specified below:

Item(s)

_____

_____

_____

Patient/Guardian signature:_____

Witness:_____

Date:_____

.....

Autorizacion y Solicitud De Liberacion De Registros Medicos

Fecha:_____

Nombre del paciente:_____

SS#_____ Fecha de Nacimiento_____

Titular de registros medicos:_____

Doy Autorizacion al titular mencionado antierormente para recibir mi historia medica.

Firma del paciente:_____ Fecha:_____

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PLEASE BE ADVISED, IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT OR IF YOU DO NOT GIVE 24 HR NOTICE OR DO NOT SHOW UP AT ALL, YOU WILL BE BILLED $30.00

YOU WILL BE REQUIRED TO PAY THE $30.00 BEFORE YOU ARE ABLE TO SCHEDULE A NEXT APPOINTMENT

THANK YOU.

……

POR FAVOR ATIENDA A ESTA NOTIFICACION, SI USTED NO PUEDE ASISTIR A SU CITA O NO LLAMA A CANCELAR LA CITA ENTRE 24 HORAS,USTED SERA COBRADO $30.00.

USTED TENDRA QUE PAGAR LOS $30.00 ANTES DE PODER HACER UNA PROXIMA CITA.

GRACIAS.

_____ _____

SIGNATURE/FIRMA DATE/FECHA

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PATIENT ACKNOWLEDGEMENT AND RECEIPT OF PRIVACY PRACTICES

I _____ have read and received a copy of the notice of privacy practices.

Signature of patient:_____

Date:_____

Witness:_____

……..

PRACTICA DE PRIVACIDAD

Yo_____ he leido y recibido una copia del aviso de practicas de privacidad.

Firma del Paciente: _____

Fecha: _____