The purpose of the disclosure is: ***(Initial all that apply):***

☐ Continuation of Care
☐ Changing Healthcare Providers
☐ Personal Reasons (at the request of the individual)
☐ Insurance
☐ Second Opinion/Consult
☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse. State and federal law protect the following information. If this information applies to you, please indicate if you don't authorize the disclosure of the following information, which may be included in the health information listed above. ***(Check all that apply):***

☐ STD / HIV / AIDS	☐ Alcohol, Drug, or Substance Abuse	☐ Mental Health	☐ Genetic Data

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Expiration of Authorization:

This authorization will remain in force and effect under the following conditions: ***(Initial all that apply):***

☐ From the date of this Authorization until the following date: _____/_____/_____

☐ Until the happening of the following expiration event:

If I do not specify any expiration date or event, then this Authorization will expire twelve (12) months from the date on which I sign the Authorization.

I understand that, as set forth in The Harvey Center for Integrative Medicine Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending notification to:

Functional Medicine Florida
3982 Bee Ridge Road, Suite J
Sarasota, FL 34232

- I understand my revocation will not apply to information already retained, used or disclose in response to this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the office will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that I have the right to:
  - Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
  - Refuse to sign this authorization.

I certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

_____ _____
Signature of Patient or Personal Representative | Date

_____ _____
Print Name of Patient or Personal Representative | Description of Personal Representative's Authority

Official Use Only

Completed/Witnessed by: _____ (Print Full Name) Date Completed: _____

Delivery method : ☐ FAXED TO THE HEALTHCARE PROVIDER ☐ MAILED

SKIN, DRYNESS OF	MILD	MODERATE	SEVERE
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES	**MILD**	**MODERATE**	**SEVERE**
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS	**MILD**	**MODERATE**	**SEVERE**
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of finger nails			
Toenails			
White spots/lines			
RESPIRATORY	**MILD**	**MODERATE**	**SEVERE**
Bad breath			
Bad odor in nose			
Cough-dry			
Cough-productive			
Hay fever: Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			

RESPIRATORY, CONT'D	MILD	MODERATE	SEVERE
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR	**MILD**	**MODERATE**	**SEVERE**
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			
URINARY	**MILD**	**MODERATE**	**SEVERE**
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			