2040 Oakley Seaver Dr. Clermont, FL 34711 – Phone: (352) 242-1665, Fax: (352) 243-1649
2320 North Blvd Suite C, Davenport, FL 33837 – Phone: (863) 547-9610, Fax (863) 547-9614

Rajab Abu Khadrah, MD, FACG
Fadi Rahhal, MD
Khalid Maqsood, MD, FACG, FACP
Tammy King-Harvey, ARNP

New Patient Information

Last Name	**First Name**	**M.I.**	**Gender** ☐M ☐F	**Date of Birth**	**Social Security**
Patient's Address		**City**		**State**	**Zip**
Home Phone	**Cell/Alt Phone**		**Work Phone**		
E-Mail:					
Name of Insured		**Relationship to Insured (self, spouse, other)**			
Emergency Contact	**Relationship**		**Phone**		
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other					
Primary Care Physician		**Referring Physician**			
Pharmacy Name	**Pharmacy Address**			**Pharmacy Phone**	
Reason for today's visit					

PATIENT AGREES AND CONSENTS TO THE PRACTICE RELEASING INFORMATION TO PATIENT IN THE FOLLOWING ALTERNATIVE MANNERS (PLEASE **INITIAL** THE APPROPRIATE SPACES BELOW):

____VIA E-MAIL TO THE PATIENT'S DESIGNATED E-MAIL ADDRESS PROVIDED ABOVE
____ VIA REGULAR MAIL WITH ANY ENVELOPES BEING MARKED PERSONAL AND CONFIDENTIAL AND ADDRESSED TO PATIENT.
____ VIA TELEPHONE, IF PATIENT CONTACTS THE PRACTICE AND PROVIDES THE APPROPRIATE INFORMATION (INCLUDING THE PATIENT'S NAME, SOCIAL SECURITY NUMBER AND UNIQUE PERSONAL IDENTIFIER).

Certification

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I UNDERSTAND IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE OF ANY INSURANCE CHANGES OR PLAN UPDATES AND TO SUBMIT TO THEM MY INSURANCE CARDS FOR COPYING. I UNDERSTAND IT IS ALSO MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY NAME CHANGES AND ADDRESS CHANGES OR UPDATES.

______________________________________ ______________________________________
SIGNATURE OF __PATIENT__PERSONAL REPRESENTATIVE* DATE

______________________________________ ______________________________________
PRINTED NAME *IF PERSONAL REPRESENTATIVE, RELATIONSHIP TO PATIENT

2040 Oakley Seaver Dr. Clermont, FL 34711 – Phone: (352) 242-1665, Fax: (352) 243-1649
2320 North Blvd Suite C, Davenport, FL 33837 – Phone: (863) 547-9610, Fax (863) 547-9614

Rajab Abu Khadrah, MD, FACG **Khalid Maqsood, MD, FACG, FACP**
Fadi Rahhal, MD **Tammy King-Harvey, ARNP**

CONSENT TO USE OR DISCLOSE INFORMATION FOR
TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS & HIPAA NOTICE OF PRIVACY PRACTICES

THE PATIENT HEREBY CONSENTS TO THE USE OR DISCLOSURE OF HIS/HER INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("PROTECTED HEALTH INFORMATION") AND PATIENT MEDICAL RECORD INFORMATION BY **RAJAB ABUKHADRAH, MD; KHALID MAQSOOD, MD; FADI RAHHAL, MD** IN ORDER TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PATIENT SHOULD REVIEW THE PRACTICE'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF THE POTENTIAL USES AND DISCLOSURES OF SUCH INFORMATION, AND THE PATIENT HAS THE RIGHT TO REVIEW SUCH NOTICE PRIOR TO SIGNING THIS CONSENT FORM.

THE PRACTICE RESERVES FOR ITSELF THE RIGHT TO CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES AT ANY TIME. IF THE PRACTICE DOES CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES, PATIENT MAY OBTAIN A COPY OF THE REVISED NOTICE IN THE OFFICE OR BY SENDING A WRITTEN REQUEST TO **SOUTHLAKE GASTROENTEROLOGY, 2040 OAKLEY SEAVER DR.CLERMONT, FL 34711.**

PATIENT RETAINS THE RIGHT TO REQUEST THAT THE PRACTICE FURTHER RESTRICT HOW HIS/HER PROTECTED HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE PRACTICE IS NOT REQUIRED TO AGREE TO SUCH REQUESTED RESTRICTIONS; HOWEVER, IF THE PRACTICE DOES AGREE TO PATIENT'S REQUESTED RESTRICTION(S), SUCH RESTRICTIONS ARE THEN BINDING ON THE PRACTICE.

PATIENT ACKNOWLEDGES AND AGREES THAT THE PRACTICE MAY DISCLOSE PATIENT'S PROTECTED HEALTH INFORMATION AND PATIENT MEDICAL RECORD INFORMATION TO THE FOLLOWING INDIVIDUALS WHO ARE EITHER THE PATIENT'S FAMILY MEMBERS, LEGAL REPRESENTATIVES, GUARDIANS, HEALTH CARE SURROGATES, OR HAVE POWER OF ATTORNEY ON BEHALF OF THE PATIENT:

WITH THIS CONSENT, RAJAB ABUKHADRAH, MD; KHALID MAQSOOD, MD; FADI RAHHAL, MD MAY DISCUSS MY MEDICAL INFORMATION WITH:

NAME:_________________________________ RELATIONSHIP:__________________PHONE #:______________________

NAME:_________________________________ RELATIONSHIP:__________________PHONE #:______________________

NAME:_________________________________ RELATIONSHIP:__________________PHONE #:______________________

THE PATIENT AGREES THAT THE PRACTICE MAY DISCLOSE THE FOLLOWING TYPES OF INFORMATION CONTAINED IN THE PATIENT'S MEDICAL RECORDS (PLEASE **INITIAL** THE APPROPRIATE CATEGORIES LISTED BELOW):

_____ HIV/AIDS INFORMATION

_____ MENTAL HEALTH INFORMATION

_____ SUBSTANCE ABUSE INFORMATION

_____ SEXUALLY TRANSMITTED DISEASE INFORMATION

2040 Oakley Seaver Dr. Clermont, FL 34711 – Phone: (352) 242-1665, Fax: (352) 243-1649
2320 North Blvd Suite C, Davenport, FL 33837 – Phone: (863) 547-9610, Fax (863) 547-9614

Rajab Abu Khadrah, MD, FACG
Fadi Rahhal, MD
Khalid Maqsood, MD, FACG, FACP
Tammy King-Harvey, ARNP

MEDICAL RECORDS REQUEST

Requested From Doctor: ____

Doctor Telephone:_________________Doctor Fax: ___________________

Patient Name: ____

Date of Birth: _____________________ SSN: ________________________

I, ________________________________, request that any and all medical records specified below shall be released to South Lake Gastroenterology.

Office Notes	**Radiology/Nuclear Medicine Report**	**Laboratory Reports**
Operative Reports	**Pathology Reports**	**Hospital Records**

Please fax records to **352-243-1649**, or mail to the address listed above.
PLEASE BE ADVISED THAT THIS IS TO BE CONSIDERED A FULL AND COMPLETE AUTHORIZATION TO RELEASE ALL MEDICAL RECORDS TO THE ABOVE MENTIONED FACILITY.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THE PROVIDER/FACILITY. INSURANCE COMPANY LISTED ABOVE AS THE RELEASING AGENCY IS RELEASED FROM AS LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED.

I FURTHER UNDERSTAND THAT I AM AUTHORIZING THE RELEASE OF INFORMATION FROM THE RECORDS WHOSE CONFIDENTIALITY AND PRIVELEDGED STATUS IS PROTECTED FROM FLORIDA STATUTE AND THAT A RE-DISCOLOSURE OF THIS INFORMATION BY THE RECEIVING AGENCY IS PROHIBITED WITHOUT WRITTEN EXPRESS PERMISSION FROM THE PATIENT.

Signature of Patient or Empowered Representative____________________________________

Witness ________________________________ Date: _______________________________________

VALID FOR A YEAR AFTER RECIEVED