T·B·O·S

Tampa Bay Orthopaedic & Spine

MINIMALLY INVASIVE SURGICAL INNOVATIONS

David Wall, MD **Brett Menmuir, MD**

1811 N Belcher Rd., Suite H-2
Clearwater, FL 33765
Phone: 727-724-6373
Fax: 727-724-6377

Patient Information

Date_____ Home Phone_____ Email_____

Name_____ SS#_____

Address_____ Cell Phone_____

City_____ State_____ Zip_____

Sex ☐M ☐F DOB_____ ☐Married ☐Widow ☐Single ☐Divorced/Separated ☐Minor

Patient Employer/School_____ Occupation_____

Employer/School Address_____ Phone_____

Emergency Contact_____ Phone_____

Family/Referring Dr_____ Phone_____ Fax_____

Primary Insurance

Insured Name_____ DOB_____

Address (if different than above)_____ Phone_____

City_____ State_____ Zip_____ SS#_____

Insured Employer_____ Wk Phone_____

Insurance Company_____

Subscriber ID #_____ Group #_____

Insurance Address_____ Phone_____

City_____ State_____ Zip_____ Fax #_____

Worker's Compensation or MVA Information

Claim #_____ Date of Injury_____

WC/MVA Co. Name_____ Phone_____

Address for Claims_____

Adjuster Name_____ Phone_____ Fax_____

Attorney Name_____ Phone_____ Fax_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize David Wall, MD or my insurance company to release any information required to process my claims.

_____

Patient/Guardian Signature Date

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Patient: _____ Age: _____ DOB: _____
Height: _____ Weight: _____ _____ Auto/ Motorcycle Injury ____ Slip & Fall ___ Pedestrian
Date of Injury: _____ Today's Date: _____

What is the main reason you are here.

_____

If this was as a **result of an accident** please explain exactly how you were injured, if not, skip to section 2 below

_____

_____

Were you the ___ Driver ___ Passenger ____ Front ___ Back Did you have on your seatbelt ___ Yes ___ No
Did you strike your head against the vehicle? ___ Yes ___ No Did you lose consciousness ___ Yes ___ No
Did any parts of your body strike the vehicle or the ground , please list which areas _____
_____, _____, _____, _____
Following the injury, did you go to the hospital ____ Yes ___ No Admitted? ___ Yes ___ No
Name of Hospital _____
Please indicate any of the procedures performed at the hospital ___ Surgery ___ CAT scan
____ X rays ____ Prescription for medications provided _____ Stitches (continue to Section 2)

Section 2

Please indicate all doctors you have seen for this medical condition and the type of care they have provided. If none, please skip

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Doctor _____ Date seen _____
Treatments _____

Please check any of the following medical treatments you have had FOR YOUR INJURIES

_____ Surgery for _____ Name of doctor _____

_____ Injections Areas injected _____ Name of doctor _____

Did Treatment help? ____ Yes ____ No Explain _____

(For below, please check if this pertains to your pain)
Please describe each painful area you have at this time

_____ **Low Back Pain**
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travel to either buttock or leg ___ Yes ___ No If yes, ___ Left ___Right leg
If yes, describe the pain _____
Please check any of the following you have in your legs ____ Numbness ____ Pins and needles
____ Weakness in my ____ Left / Right / Both leg(s)
Does anything lessen your pain? ___ Yes ___ No Describe _____
Does anything worsen your pain? ___ Yes ___ No Describe _____
___ Previous injuries, if any, to Low Back ____ Completely recovered ____ Still had pain from old injury,
Please note how new pain is different than old _____

_____ **Neck Pain**
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travels to either arm ___ Yes ___ No If yes ___ Left ___ Right arm
If yes, describe the pain _____
Please check any of the following you have in your arms ____ Numbness ____ Pins and needles
____ Weakness in my ____ Left / Right / Both arm(s)
Does anything lessen your pain? ___ Yes ___ No Describe _____
Does anything worsen your pain? ___ Yes ___ No Describe _____
___ Previous injuries, if any, to Neck ____ Completely recovered ___Still had pain from old injury
Please note how new pain is different than old _____

_____ **Headaches** that are in ____ Front of head ____ Back of head ____ All of head
with ____ dizziness ____ change in vision ____ passing out ___ nausea and vomiting
Additional comments _____

Additional Painful Area (where?)_____
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travels to another area of your body from original area ___ Yes ___ No
If yes, describe _____
Does anything lessen your pain? ___ Yes ___ No Describe _____
Does anything worsen your pain? ___ Yes ___ No Describe _____
Additional comments (ex. Popping, Locking)_____

Additional Painful Area (where?)_____
___ Ache ___ Burning ___ Sharp ___ Other _____
Does pain travels to another area of your body from original area ___ Yes ___ No
If yes, describe _____
Does anything lessen your pain? ___ Yes ___ No Describe _____

Does anything worsen your pain? ___ Yes ___ No Describe _____

Additional comments (ex. Popping, Locking)_____

Past Medical History

Check all that apply

_Diabetes
_Asthma
_Hypo/Hyper Thyroid
_Kidney disease
__Other:_____

_High Blood Pressure
_Bronchitis or Emphysema
_Rheumatoid Arthritis
_Hepatitis
_ HIV+ (this will not be disclosed)

_Heart Disease
_Seizure history
_History of Cancer
type: _____

_Heart Attack
_Ulcers
_Blood Clots

Past Surgical History

Please list any surgeries you have had _____, _____
_____, _____, _____

CURRENT MEDICATIONS (List all medications you are taking NOW -use back of this sheet if you need more room)

MEDICATION	DOSAGE	# Per Day /Frequency	Reason for Taking (if known)

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES NO List name and describe reaction

_____
_____

Family Medical History

Has anyone in your family had an adverse reaction to anesthesia: Yes No

Has anyone in your family had a history of alcoholism or drug addiction Yes No

Social History

Who do you live with now: SPOUSE BY YOURSELF OTHER FAMILY FRIENDS OTHER _____

Do you smoke tobacco? YES NO How much? _____ packs per day How long? _____ years

Do you drink alcohol? YES NO How much? _____drinks per day How long? _____years

Have you previously had a history of ___ alcohol abuse ___ drug abuse When did you discontinue use_____

Occupation _____ Time lost from work _____

Have you returned to your workplace ____ Yes ___ No

DO YOU HAVE ANY PROBLEMS RELATED TO THE FOLLOWING?

Neurological
Tremors Y N
Dizzy Spells Y N

Gastrointestiona
Abdominal Pain Y N
Nausea/Vomiting Y N
Rectal Bleeding Y N
Ulcers Y N

Respiratory
Frequent Cough Y N
Short of Breath Y N
Wheezing Y N

Hemotologic/Lymphatic
Blood Clots Y N
Easy Bleeder" Y N

General
Fever Y N
Weiight loss Y N

Cardiovascular
Chest Pain Y N
High B.P. Y N
HeaH Failure Y N

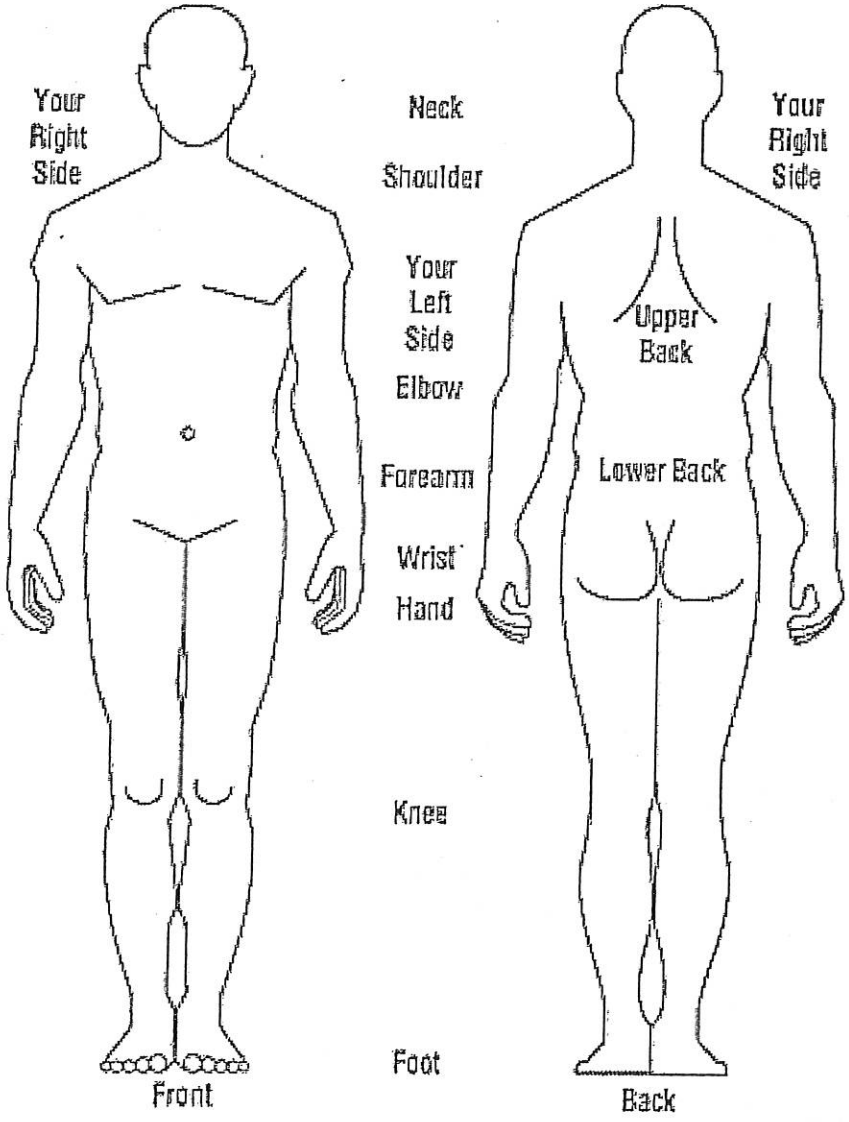
Musculoskeletal
Joint Pain Y N
Muscle Adches Y N
Fiibromyalgia Y N

Psychologic
History of depression Y N
History of bipolar disorder Y N
History of schizophrenia Y N

Genitourinary
Unrine Retention Y N
Loss of bladder control Y N

Other Medical Conditions that we should be aware of that you have not mentioned so far:
_____
_____

Shade in the areas where you have pain



PATIENT / PHYSICIAN AGREEMENT

FAILURE TO FOLLOW PHYSICIAN ORDERS

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can include but is not limited to missing, postponing, or refusal of additional tests to rule out, confirm, or discover illness. Also, missing postponing, or refusal of making scheduled appointments can be considered failing to follow physician's orders. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

PRESCRIPTION REFILLS

Please don't wait until you run out of medicine to call for a refill. In fact, call at least two days ahead. In order to protect you, your doctor must review your medical file before renewing a prescription. Therefore, please do not call for medications after hours or on weekends when records are unavailable. **It could take up to 48 hours after you call before your doctor can review your file and call in any prescription.** The files are reviewed, and prescriptions are called to pharmacies at the end of office hours after all patients have been seen. By law, doctors cannot order refills for certain narcotics over the phone. A written prescription is required in those cases. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

MEDICAL RECORDS

Your records are kept in strict confidence as part of our permanent file. We will release copies only if we have your written permission. We prefer to mail copies of records, but we will give them to you in person to hand-carry if time is critical. **Please give us at least 48 hours notice prior to coming in and picking up records as it does take some time to get things together for you.** I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

STATEMENT OF FINANCIAL RESPONSIBILITY

I the undersigned realize that all medical and surgical charges incurred by me or my dependent/s are my financial responsibility. All court fees, attorney fees, and other fees necessary to collect this amount are payable by me. I grant consent to Tampa Bay Orthopaedic & Spine and/or Wall Healthcare to use and disclose my protected health information for the purposes of diagnosing or providing treatment and conducting surgical operations. My protected health information includes demographic information which is collected from me, created or received by my physician or another health care provider, and my employer. This protected information relates to my past, present, and future physical and mental health condition/s. I can receive from Tampa Bay Orthopaedic & Spine and/or Wall Healthcare a copy of the Notice of Privacy Practices prior to signing this document and understand it is subject to change. I understand that diagnosis and treatment of me Wall Healthcare, Inc may be conditioned upon my consent as evidenced by my signature on this document. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

CONFIDENTIALITY

The physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method that can assist with the care of the patient. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

INDIVIDUAL PATIENT AUTHORIZATION

Name the people and/or organization and their relationship to you that are authorizing to use and/or disclose your personal health information:

_____

IRREVOCABLE MEDICAL LIEN

I hereby do authorize any and all parties, including any insurance company and my attorney (if applicable), to pay directly to Tampa Bay Orthopaedic & Spine and/or Wall Healthcare sums as may be due and owing for medical services rendered to me and to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Tampa Bay Orthopaedic & Spine and/or Wall Healthcare. If applicable, I also authorize my attorney to **release any and all information** without limitation regarding any legal proceedings, judgments, or settlements that will aide in the recovery of Tampa Bay Orthopaedic & Spine and/or Wall Healthcare's unpaid sum.

I fully understand that I am directly and fully responsible to Tampa Bay Orthopaedic & Spine and/or Wall Healthcare for all medical bills incurred by me for services rendered in consideration of waiting for payment. I further understand that such payment is **not** contingent on any settlement, judgment, or verdict by which I may eventually recover said fee.

I hereby further give my authorization to Tampa Bay Orthopaedic & Spine and/or Wall Healthcare to record a Uniform Commercial Code Form (UCC-1) to protect this medical lien and to send any unpaid sum to the Tortfeaser. I have read, understand, and agree with the above.

Patient/Guardian Signature:_____ Date:_____

I CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION IN THE PATIENT INTAKE FORMS ARE ACCURATE.

Patient/Guardian Signature:_____ Date:_____

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Assignment of Benefits

Patient:_____ Date of Loss:_____

Insurance Carrier:_____ Claim #:_____

Policy Owner's Name:_____ Policy #:_____

For and in consideration of (PATIENT'S NAME):_____ agreeing to pursue the responsible automobile insurance carrier for payment of benefits due and not requiring prepayment of services, I hereby irrevocably assign ALL rights and benefits to TAMPA BAY ORTHOPAEDIC & SPINE for Personal Injury Protection, Medical Payment Coverage and other benefits which I may have in accordance with Florida stature 627.736. This includes any benefits from my insurance company and any other entity which may be responsible for medical expenses incurred. I further authorize TAMPA BAY ORTHOPAEDIC & SPINE. to collect payments & prosecute any necessary actions to collect payment for services as they see fit and allowable by law and contract. THIS DOCUMENT CONSTITIUTES AN ABSOLUTE ASSIGNMENT OF RIGHTS AND BENEFITS AS CONTEMPLATED IN PROGRESSIVE AMERICAN INS. CO. V. STAND-UP MRI OF ORLANDO, 990 SO.2D3 (FLA. 5TH DCA 2008).

I hereby further give a lien to TAMPA BAY ORTHOPAEDIC & SPINE against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injures or illness for which I have been treated by TAMPA BAY ORTHOPAEDIC & SPINE as a result of the above stated loss date. This document acts as an irrevocable and absolute assignment of all my rights and benefits under all policies of insurance for which I am entitled to coverage thereupon. I agree to cooperate with all employees of TAMPA BAY ORTHOPAEDIC & SPINE and their attorney's (at their choosing), and to do all things reasonable to effect payment of the bills by the insurance company or other entity to TAMPA BAY ORTHOPAEDIC & SPINE including but limited to: disclosing my medical condition, being available for factual discovery, or any other means of cooperation.

TAMPA BAY ORTHOPAEDIC & SPINE hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement, or agreed by the provider to accept a reduced amount as payment in full.

This assignment concerns amounts due TAMPA BAY ORTHOPAEDIC & SPINE and those costs including but limited to: attorney fees, court costs, special report or narrative fees, other costs, and interest necessary to procuring payment from the above-named insurance company and/or other entities. This assignment is not intended to assign any other causes of action that may belong to the undersigned patient. I agree to pay any applicable deductible/s, co-insurance/s, co-payment/s, or any not covered items by any policy of the insurance cited above. I understand that as a benefit and convenience to me, TAMPA BAY ORTHOPAEDIC & SPINE will bill and pursue collection against the insurance company or other responsible party on my behalf. I hereby instruct and direct my insurance company to pay benefits directly to TAMPA BAY ORTHOPAEDIC & SPINE at the address provided on the bill.

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TAMPA BAY ORTHOPAEDIC & SPINE's medical care is being provided for a reasonable fee for treatment casually related to the above loss date and is medically necessary. I instruct my insurance carrier or other responsible entity to pay these bills to the full extent of my available benefits under the insurance policy and Florida law. I hereby give TAMPA BAY ORTHOPAEDIC & SPINE limited Power of Attorney to endorse and sign my name on any draft for payment to TAMPA BAY ORTHOPAEDIC & SPINE.

This agreement is intended to serve as an absolute assignment of rights and benefits under my policy of insurance in favor of TAMPA BAY ORTHOPAEDIC & SPINE if any language within this agreement has the effect of invalidating this agreement, that language shall be deemed void and the remainder of the assignment shall maintain full force and effect. A photocopy of this agreement shall be considered as effective and valid as the original.

As TAMPA BAY ORTHOPAEDIC & SPINE stands in my shoes by virtue of this assignment, the following constitutes rights now owned by WALL TAMPA BAY ORTHOPAEDIC & SPINE, as I have directed herein, and TAMPA BAY ORTHOPAEDIC & SPINE hereby demands, including but limited to:

A. Providing a copy of any applicable insurance policy, declaration page, all applicable endorsements.
B. Transcripts and/or copies or recorded statements, examinations under oath, affidavits of the claimant, affidavits of any provider who treated me, or other sworn statements pursuant to Addison v. Geico General Ins. Co., 17 Fla. L. Weekly Supp. 272a (Hills. Cty. Ct. 2010).
C. Copies of independent or compulsory evaluation, including peer reports or other reports pursuant to 627.736(7) of me.
D. Any police or accident report my insurance company may have for the above listed date of loss.
E. A listing of all PIP benefits paid to date on my behalf of AND to me which shall include claims were received, the amount of the claim before reductions or repricing, payment amount or denial of each claim, the amount of the deductible and the claims applied thereto, and whether benefits have been exhausted and the amount of PIP benefits available, commonly known as a "PIP LOG" of "PIP PAYOUT LOG". This is specific to include ALL medical, disability, and death claims under accordance with Florida statute 627.736 and the names of each biller and payee.
F. Providing notice or any request under any cooperation clause of the policy, including but not limited to: requests for EUO or IME attendance to our office as WE STAND IN THE SHOES OF THE INSURED. Any EUO or IME taken without providing us reasonable notice and allowing counsel of our choosing to attend is INVALID.
G. All notices and requests for information under Florida Statute 627.736(6)(b) are to be directed to our attorney, MARIUS J. GED, ESQ., GED LAWYERS, LLP, 7171 N. Federal Highway, Boca Raton, Florida 33487.

Patient/Guardian's Name Patient/Guardian's Signature Date

IF PATIENT IS INCAPACITATED OR UNDER THE AGE OF 18, PLEASE INDICATE THE PATIENT NAME, GUARDIAN NAME RELATION TO PATIENT, AND OBTAIN GUARDIAN SIGNATURE.

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NOTICE OF PRIVACY PRACTICES

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

At TBOS, LLC. we have always kept your health information secure and confidential. The Health Insurance Portability and Accountability Act hat requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice at any time upon request.

If we change any details of this notice, we will notify you in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Barbara Knapp at (727) 446-5681. This notice went into effect on October 01, 2007.

Acknowledgement: I have read, understand, and agree with the above Notice of Privacy Practice.

Patient/Guardian (Please Print Name) Patient/Guardian (Signature) Date

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"No-Show" Agreement

The following represents a legal agreement between TBOS and the patient, _____.

I understand that by making an appointment for a follow up evaluation or an in-office injection procedure, I am agreeing to be present at the arranged time for this appointment. I understand that TBOS is reserving this time specifically for my care.

In addition to the above, failure to follow pre-procedure instructions may result in cancellation of the procedure by the doctor. Such cancellation, based upon my own failure to follow instructions, will be deemed a failure to be present for my appointment and will be handled as below.

After reading the above, I understand that failure to be present for my appointment without 24-hour notice OR failure to follow pre-procedure instructions resulting in procedure cancellation on the day of the procedure will result in a charge to be billed to my account for which I am financially responsible

_____
Patient name (print)

_____
Signature patient

_____
Date

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

Initial Evaluation

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately,** and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled,** or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date
David Wall, MD	MD	

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

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Name *(PRINT or TYPE)*	Signature	Date
Brett Menmuir, MD		

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Medical Records Release Authorization
To avoid a delay, this form must be completed in its entirety.
PLEASE PRINT CLEARLY

Patient Name: _____ Maiden Name: _____

D.O.B. **(Required)**_____ SS#**(Required)**_____

Home Phone: _____ Work Phone: _____

Permission is hereby granted to TBOS to request medical information to the individual / organization as noted below or to have records released to TBOS:

Mail to: ☐ Name: _____

Address: _____

City/State/Zip: _____

☐ Fax to another medical entity (____)_____

☐ call when ready for pick up (____)_____

☐ Person picking up records

Please check information to be released:

☐ All records, excluding records from other physicians.
☐ Surgical Records
☐ Therapy reports
☐ Diagnostic test results
☐ Other _____
☐ Office Notes only
☐ X-ray/MRI films
☐ X-ray/MRI reports
☐ Patient information

This authorization will be valid for two years after the date of the patient's signature as it appears below, or by whichever comes sooner.

_____
Signature of Patient / Legal Guardian Date

I understand I have the right to refuse this authorization, in writing, and TBOS is released from all legal liability that may arise from the released information requested.

_____ _____
Signature of patient/Legal Guardian Date