Jeannine Stein, MD
AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____Fax Number: _____

☐ **Access Request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

2. The type of information to be used or disclosed is as follows (please include dates of service)

Date(s) of Service: **ANY**

☐ Complete Medical Record

☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)

☐ History & Physical (H&P)
☐ Discharge Summary
☐ Operative Report
☐ Consultation Reports
☐ X-ray and imaging reports
☐ Progress Notes
☐ Laboratory Test Results
☐ Immunization Record

☐ Other- list specific Items: _____

Behavioral Health Reports:

☐ Social History
☐ Client Data Form
☐ Referral/Treatment Form
☐ Admission Evaluation
☐ Notification of Admission
☐ Treatment Plan
☐ Academic History
☐ Aftercare Instructions
☐ Psychological Evaluation

☐ Other – list specific items: _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse.

This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

5. This information may be disclosed to and used by the following individual/organization:

Name:

For the purpose of:

☐ Further Medical Care
☐ Inspection/Copying of my records
☐ Personal
☐ Other (please specify):_____
☐ Insurance Eligibility/Benefits
☐ Legal Investigation or Action
☐ Changing Physicians

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #6 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 90 days, unless otherwise specified.**

_____ _____
Signature of Patient Date

(If signed by someone other than the patient, indicate relationship and authority to do so.)

_____
Name of Patient (Please Print)

Patient is:
☐ Minor ☐ Incompetent
☐ Disabled ☐ Deceased

Legal Authority:
☐ Custodial Parent
☐ Executor of Estate of Deceased
☐ Authorized Legal Personal Representative
☐ Legal Guardian
☐ Power of Attorney for Health Care

_____ _____
Signature of Witness Date

THE CENTER FOR Skin Cancer SURGERY

Health History Questionnaire

Name: _____ Age: _____ Date of Birth: _____

Address: _____ Nickname: _____

_____ Today's Date: _____ Gender:_____

Home Phone: _____ Cell Phone: _____ Referred By: _____

Current Complaint/Illness (please describe): _____

_____ E-Mail Address: _____

Current Adult Medical Conditions

(i.e. high blood pressure, diabetes, etc.) Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Previous Surgeries Date

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Current Tobacco Use: ◯ YES ◯ NO

Current Alcohol Use: ◯ YES ◯ NO

	Amount	Duration
Cigarettes:	_____	_____
Pipe/Cigar:	_____	_____
Chewing:	_____	_____
Alcohol:	_____	_____

Medical Allergies

_____

_____

_____

_____

_____

_____

_____

Current Medications with Dosage

_____

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Mohs Micrographic Surgery
Patient Information

Mohs Micrographic Surgery (MMS) is one of the methods used to remove a variety of skin tumors. It is different from other procedures used to treat skin cancers because of the meticulous checking of 100% of the surgical margins to assure that the entire tumor has been eliminated. Although MMS is a time-consuming and complex procedure, it provides the best chance for curing the cancer and also results in the smallest amount of skin being removed. Therefore, MMS is typically used for aggressive tumors, tumors in areas of function/cosmetic concern (nose, eyelid, lip, face), or those cancers which have not responded to other treatment methods.

The surgery is performed with local anesthesia in the office surgical suite. One of our surgical team members will review your medical history. Your surgeon will next meet with you and discuss important points about your specific skin cancer, the MMS procedure, anticipated plans for reconstruction, and probable postoperative requirements. The site of the tumor is then cleaned, marked and numbed. A thin layer of skin is removed. A dressing is next placed and you are escorted back to the waiting room. While there, you may relax, eat, drink, visit with family, read, or listen to music. The surgeon will draw a map to correspond exactly to the wound which has been made. The tissue which was removed is immediately taken to the lab, where it is cut into sections, placed on slides, stained, and returned to the surgeon for interpretation. Your surgeon will then view the slides under the microscope, determine if the cancer is still present, and illustrate the site and amount of cancer on the map. This process requires 30-90 minutes, depending on the size and type of tissue removed. If any remaining tumor is noted, you will then return to the operating room, where additional tissue will be removed only where the cancer persists. The tissue is again mapped, prepared, and interpreted. This process continues until the entire tumor has been removed. Although all patients hope to be cleared of tumor with a single stage, the average number of stages for a given tumor is two or three.

Once the entire tumor is removed, MMS has concluded, the process of reconstruction begins. In the vast majority of cases, this can be accomplished on the same day in the office setting. For unusually large or difficult wounds, reconstruction may be delayed or staged, or referral to a specific specialist may be required. Your surgeon will consider reconstructive options and illustrate those to you. Although the doctor will recommend what is considered the best procedure, your input will be an important consideration in the final decision.

Following the reconstructive procedure, you will be given explicit written and verbal instructions regarding activity restrictions, wound care, medication usage, and what to expect in the postoperative period. All of your questions will be answered. If further questions arise, the written material provided to you will commonly answer these. For additional questions or problems, you will be able to contact a member of our surgical team at any time.

For those patients who desire more information, the following website is well written and provides correct, useful information: www.skincancermohssurgery.org.

PRIVACY NOTICE ACKNOWLEDGEMENT

PURPOSE: This form is used to document (a) an individual's acknowledgment of receipt of our Privacy Practice Notice or (b) when we have not obtained this acknowledgment, our good faith effort to obtain the acknowledgment. **This notice is available in print at our office or on our website**.

Patient Name: _____ Date of Birth: _____
Notice Version (date): February 11, 2020

Acknowledgment of receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Privacy Practices Notice from The Center for Skin Cancer Surgery, Inc. at 7960 N Wickham Road, Suite 105, Melbourne, FL 32940.

Individuals who may receive my medical information:
Name/Phone: _____
Name/Phone: _____
Name/Phone: _____
Name/Phone: _____

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgment of receipt):
Describe your good faith effort to obtain the individual's signature on this form: _____
_____

Describe the reason why the individual would not sign this form: _____
_____

(TO BE COMPLETED BY OFFICE STAFF)
I attest that the above information is correct.

Signature: _____ Date: _____

Print Name: _____ Title: _____