MEDICATION & VITAMIN RECORD

DRUG NAME:	DOSAGE/ STRENGTH:	REGIMEN/ FREQUENCY:	PRESCRIBING DOCTOR:	PRESCRIBED FOR:
Example: SYNTHROID	Example: 0.88 MCG	Example: ONCE A DAY	Example: DR. GRIFFIN	Example: THYROID

Pharmacy: _____ Phone number: _____

Patient Name: _____ Patient DOB: _____

Signature: _____ Date: _____

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DRUG NAME:	DOSAGE/ STRENGTH :	REGIMEN/ FREQUENCY:	PRESCRIBING DOCTOR:	PRESCRIBED FOR:

Pharmacy: _____ Phone number: _____
Patient Name: _____ Patient DOB: _____

Signature: _____ **Date:** _____

Patient Disclosure Form

Five County Foot Care **Dr. Frank J. DiPalma**

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. You are also provided the right to request confidential communications or that a communication of protected health information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (please check all that apply):

Mobile (Cell) Telephone	Home Telephone	Work Telephone
☐ OK to leave message with detailed information	☐ OK to leave message with detailed information	☐ OK to leave message with detailed information
☐ Leave message with call back number only	☐ Leave message with call back number only	☐ Leave message with call back number only

_____ _____

Patient Name (Print) Date

_____ _____

Patient Signature Date

We at **Five County Foot Care** value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children or any significant other) without your written consent. If you want anyone other than your referring physician to have access to your medical information, please list their name, address, relation and phone number below.

Name	Address	Phone Number	Relation