DOPSON FAMILY MEDICAL CENTER

Dr. John Coleman DPM
159 North 3rd Street
Macclenny, FL 32063
(904) 259-5277 Fax (904) 653-2093

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain all of which are *strictly* regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use:

1. All controlled substances have a potential for dependency and abuse.

2. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy you have chosen is: _____Phone:_____

3. You may not share, sell or otherwise permit others including spouse or family members to have access to these medications.

4. I will not consume excessive amounts of alcohol in conjunction with narcotics, nor will I use, purchase, or otherwise obtain any illegal drugs.

5. Medications will not be replaced if lost, stolen, get wet, or destroyed. A police report will be required prior to medications being replaced.

6. Early refills will not be given. Renewals are based upon keeping QUARTERLY scheduled appointments.

7. It is understood that failure to adhere to these policies may result in discontinuing of therapy with controlled medication by this physician and possible termination from this practice.

8. You consent that you have full rights and power to sign and be bound by this agreement, and that you have read, understand, and accept all of these terms.

_____ _____
Patient's Full Name Date

_____
Patient's Signature

Dr. John Coleman, DPM

PRACTICE INFO

Consent for Medical Information Release

There are times we are asked to give family members or others information on test results, especially if you will not be available to receive them. If you would like for us to give out information regarding your treatment and/or test results to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release and any items we should not disclose. Make your own notes if necessary for clarification.

All Information: Any and All information we have in our file related to you which may include billing information, appointments, treatment, test results, etc.

Appointment Only: Only information related to appointment dates and time.

Testing/Labs results: Only information related to the results of any testing or labs completed by our office.

Billing Inquires: Only information related to the billing of claims, payments, and/or balances on your account with our office.

Relationship	Full name of person allowed to receive information	Type of information which may be release to the person
Husband	_____	All Info Appts Only Test/Labs Billing
Wife	_____	All Info Appts Only Test/Labs Billing
Mother	_____	All Info Appts Only Test/Labs Billing
Father	_____	All Info Appts Only Test/Labs Billing
_____	_____	All Info Appts Only Test/Labs Billing

NO INFORMATION MAY BE RELEASED (Please circle if no information should be released)

_____ Print Patient Name

_____ Patient Signature

_____ Date

John Coleman, D.P.M.
159 North 3rd Street
Macclenny, FL 32063

(Please Print)

Patient's Name:_____

Date:_____

Physician's Name: (Name of Doctor we are requesting records **from/to**)

_____

Address: (if unable to provide, we must have the phone #)

_____

_____

Please specify which records to be requested:
☐ Lab
☐ X-Ray
☐ EKG
ALL MEDICAL RECORDS FROM_____ TO_____

I hereby authorize release of my medical records pertaining to the above to:

John Coleman, D.P.M
159 North 3rd Street
Macclenny, FL 32063
Ph.# (904) 259-5277 Fax # (904) 653-2093

Date:_____ Patient Signature:_____

Date of Birth:_____ Address:_____