Patient Name: ____________________________ Date: __________ Phone # _________________

DOB: ____________ email address ___________________ Account# ____________

OB Transfer Checklist – Please fax the following records to (954) 340-5275. We will not review any incomplete records.

Genetic Testing -(If none, please specify why)- ______________________________

☐ Integrated or Sequential Part 1

☐ Integrated or Sequential Part 2

☐ NIPT ☐ AFP

☐ Quad screen

☐ Declined (written documentation)

☐ Carrier screening (☐ Cystic fibrosis ☐SMA ☐Fragile X ☐ full carrier panel)

Imaging- (if none, please specify why)- ______________________________

☐ Dating sonogram only

☐ Nuchal translucency (NT)

☐ Anatomy sonogram

Standard OB panel – (if none, please specify why)- ______________________________

☐ CBC ☐ Blood type ☐ Antibody screen ☐ HIV ☐ RPR (or FTA- ABS)
☐ Hep B surface antigen ☐ Rubella titer ☐ Gonorrhea ☐ Chlamydia ☐ Pap
☐ Urine culture ☐ Hemoglobin electrophoresis (or sickle cell screen)

Other (if applicable)

☐ Thyroid studies ☐ GCT ☐ Drug screen ☐ CMP

☐ 24hr urine ☐ Hgb A1c ☐ HSV ☐ Varicella

☐ Hepatitis C

Lona Sasser, DO, LLC
3111 N University Drive Suite 308 Coral Springs, FL, 33065
Telephone: (954) 340-1050 ~ Fax: (954) 340-5275

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

X Patient Name: ____________________ ID Number: ____________________

X Date of Birth: ____________________

By my signature below, I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Persons/organizations providing the information:	**Persons/organizations receiving the information:**
X	Lona Sasser D.O.,LLC
X fax#	fax# 954-340-5275
Specific description of information (including dates):	**Purpose of requested use or disclosure:**
	for Continuation of care

The patient or the patient's representative must read and initial the following statements:

		Initials
1.	I understand that this authorization will expire on ___/___/___ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in six months.	X
2.	I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.	X
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.	X
4.	I understand that I may see and copy the information described on this form and will receive a copy of this form after it is signed.	X
5.	If I have questions about disclosure of my health information, I can contact the office staff or the physician.	X

X____________________________________ X____________________
Signature of Patient or Legal Representative Date

____________________________________ ____________________
If Signed by Legal Representative, Relationship to Patient Signature of Witness

This document will be retained by the providing organization for six years.