Dr. Sue Mitra, MD
397 N. Wickham Road, Suite 101
Melbourne, FL 32935
Phone: (321) 622-6222 | Fax: (321) 622-6660

New Patient Registration – HIPPA Release

Patient Name

First______________MI____________Last_____________

Emergency Contact:

Name____ Relationship_____________________________________

Phone# (____) _____-_______

I authorize Medical Associates of Brevard LLC to discuss my healthcare information wih the below:

Name____ Relationship_____________________________________

Phone# (____) _____-_______

Name____ Relationship_____________________________________

Phone# (____) _____-_______

Preferred appointment reminder notification:
◯Home Phone ◯Cell ◯Cell Text ◯Work Phone
◯Mail ◯E-Mail ◯ None
◯With the person(s) authorized above

Preferred medical information notification:
I authorize medical associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯Home Phone ◯Cell ◯Cell Text ◯Work Phone
◯Mail ◯E-Mail ◯ None
◯With the person(s) authorized above

Do you have a Living Will?:
◯Yes ◯ No

Do you have an Advance Directive?:
◯Yes ◯ No
If you answered Yes to either, please provide us a copy.

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine

Your HIPPA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.