PAWLEYS PEDIATRICS & ADULT MEDICINE

WELCOMES YOU!

Please complete the attached New Patient paperwork and bring it with you to your first appointment.

<u>Please also bring</u>:

- ☐ Your current insurance card(s)
- ☐ Driver's license or state issued picture ID
- ☐ Your full medication list
- ☐ Immunization record
- ☐ Any other past medical records
- ☐ A completed Medical Record Release form with phone numbers and addresses
- ☐ Any relevant legal documents

❖ **Before your appointment, please contact your insurance provider to inform them of your change of Primary Care Physician to our office.**

When you arrive, please check in at the kiosk and the receptionist will call you to the front with further instructions.

Please be prepared, payment is due at time of service.

Georgetown Internists and Pediatricians dba
PAWLEYS PEDIATRICS AND ADULT MEDICINE
64 Business Center Drive, Pawleys Island, S.C. 29585
Phone: 843-314-1314 Fax: 843-314-1308

NEW PATIENT REGISTRATION INFORMATION

Prefix_____ Patient Last Name_____ Patient First Name_____ MI____

SSN_____ Date of Birth_____ Age_____ Sex_____

Mailing Address_____ City_____ ST____ Zip_____ Country_____

Home #_____ Cell #_____ Work #_____ Ext._____

Pharmacy_____ Address_____

☐ Newspaper ☐ Valpak ☐ Post Card ☐ Internet ☐ Friend or Family ☐ Physician ☐ Employee

Who referred you to the Practice?_____

Which Primary Physician have you chosen?_____

Insured's Information *(this is the primary person of the insurance policy)*

Last Name_____ First Name_____ MI____ SSN_____

Mailing Address_____ City_____ ST____ Zip code_____ Country_____

Home #_____ Cell #_____ Work #_____ Ext._____

Date of Birth_____ Sex_____ Race_____ Relationship to Insured (Self/child/other)_____

Employer_____ Employment Status_____ Student Status_____

Insurance Carrier/Network (Please provide copy of card)_____

ID #_____ Group #_____

Parent Information *(This section is required for* ***all children under the age of 18)***

Father's Name_____ SSN_____ DOB_____ Race_____

Does child live with this parent? ☐ Yes ☐ No If NO, please provide mailing address below.

Mailing Address_____ City_____ ST____ Zip_____ Country_____

Home #_____ Cell #_____ Work #_____ Ext._____

Father's Employer_____ Employment Status_____ Student Status_____

Mother's Name_____ SSN_____ DOB_____ Race_____

Does child live with this parent? ☐ Yes ☐ No If NO, please provide mailing address below.

Mailing Address_____ City_____ ST____ Zip_____ Country_____

Home #_____ Cell #_____ Work #_____ Ext._____

Mother's Employer_____ Employment Status_____ Student Status_____

Emergency Contact_____ Phone #_____ Relationship_____

We do not file secondary insurance. Please bring a copy of your primary insurance card to EACH visit to insure filing accuracy. We file claims for anyone holding a policy with a company with whom we have an agreement. All others will be provided with the appropriate documents to file their own claims. Payment is expected on the day of your visit. We accept cash, check, Visa, MasterCard, and American Express.

Signature of Responsible Party_____ Date_____

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NEW PATIENT ACCEPTANCE OF PRACTICE POLICIES

1. I have been provided with the **Red Flag Rule** about my privacy and identity.
   ☒ YES ☐ NO

2. I have been provided with the **Notice of Privacy Practices** and understand how my medical information may be used and disclosed.
   ☒ YES ☐ NO

3. I have been provided with the **Financial Policy** and understand my responsibility.
   ☒ YES ☐ NO

4. I have been provided with the **Notice of deemed consent to HIV Blood testing** and understand my responsibility.
   ☒ YES ☐ NO

5. **Lifetime Signature Authorization for Medicare Patients and release authorization for private insurance and / or physician referrals.**
   ☒ YES ☐ NO

   A. **Medicare Patients**: Lifetime signature authorization for release of health info as needed for processing claims to Medicare and acceptance of assignment/payment of such claims.
      ☒ YES ☐ NO

   B. Lifetime signature authorizes payment of mandated Medigap benefits to Physicians if required info is listed in Item 9 and its subdivisions of the claim.
      ☒ YES ☐ NO
      *Note: This may be revoked upon patient request.

6. I have been provided with the **Release of Medical Information** and understand my responsibility.
   ☒ YES ☐ NO

7. I have been provided with the **General Consent for Treatment** and understand my responsibility.
   ☒ YES ☐ NO

8. I understand during the course of my care there may be a need to **exchange health information** with coordinating providers. I authorize the release of my information until I provide a written request to revoke authorization.
   ☒ YES ☐ NO

Patient Name_____ Date of Birth_____

Signature of Responsible Party_____ Date_____

Signature of Witness_____ Date_____

NEW PATIENT HISTORY FORM

Name:_____ Date of Birth:_____
Physician:_____ Today's Date:_____

CURRENT MEDICAL PROBLEMS □ None

_____ _____ _____ _____
_____ _____ _____ _____

PAST SURGERIES/PROCEDURES □ None

Year:_____ Type:_____ Year:_____ Type:_____
Year:_____ Type:_____ Year:_____ Type:_____

MEDICATIONS □ None

(Include ALL over-the-counter and herbal remedies)

Name	Dose	Frequency	Name	Dose	Frequency

ALLERGIES: □ None □ Hay fever □ Pets □ Food_____ □ Other_____

□ Medication (Please list below)

Medication Name	Side Effect	Medication Name	Side Effect

PERSONAL HEALTH MAINTENANCE

Last Colonoscopy Date_____ Findings_____ Next Due_____
Last Bone Density Date_____ Findings_____ Next Due_____
In the past two weeks, have you felt down, depressed or hopeless? Y N Felt little interest or pleasure in activities? Y N
Vaccines: □ Pneumovax_____ □ Prevnar_____ □ Zostavax (Shingles)_____ □ Tetanus_____
MALE: Last prostate exam/PSA test_____ Result_____
FEMALE: Last Mammogram_____ Last Pelvic_____ Result_____

FAMILY HISTORY (Include all health problems)

Relation to Patient	Age	Diabetes	Hypertension	Heart Disease	Stroke	Cancer (Type)	High Cholesterol	Other
Mother								
Father								
Brother(s)								
Sister(s)								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Sons(s)								
Daughter(s)								

SOCIAL HISTORY

Occupation_____ □ Retired □ Unemployed Marital Status_____
Smoking □ Never □ Former □ Current Packs/day_____ #of years_____ Quit Date_____
Other Tobacco Use_____ Alcohol Use: □Daily □Weekly □Rare Servings_____
Drug Use Type_____ How often_____
Diet_____ Exercise_____

OTHER PHYSICIANS INCLUDED IN YOUR CARE

Name	Specialty	Name	Specialty

PATIENT REVIEW OF SYSTEMS FORM

Name:_____ Date of Birth:_____
Physician:_____ Today's Date:_____

Do you now or have you had any problems related to the following systems? Check the appropriate box.

Constitutional Symptoms	Yes Now	Yes Past	No Never
Fever	□	□	□
Chills	□	□	□
Weakness	□	□	□
Poor Appetite	□	□	□
Weight Loss/Gain	□	□	□
Eyes			
Blurred Vision	□	□	□
Double Vision	□	□	□
Pain	□	□	□
Glasses	□	□	□
Change in Vision	□	□	□
Allergic/Immunologic			
Hay Fever	□	□	□
Drug Allergies	□	□	□
Neurological			
Tremors	□	□	□
Dizzy Spells	□	□	□
Numbness/Tingling	□	□	□
Frequent or Severe Headaches	□	□	□
Ear/Nose/Throat/Mouth			
Ear Infection	□	□	□
Sore Throat	□	□	□
Sinus Problem	□	□	□
Difficulty Hearing	□	□	□
Earaches	□	□	□
Cardiovascular			
Chest Pain	□	□	□
Varicose Veins	□	□	□
High Blood Pressure	□	□	□
Heart Murmur	□	□	□
Irregular Heartbeat	□	□	□
Swelling of Legs	□	□	□
Use of Oxygen	□	□	□
Gastrointestinal			
Abdominal Pain	□	□	□
Nausea/Vomiting	□	□	□
Indigestion/Heartburn	□	□	□
Diarrhea	□	□	□
Blood in Stool	□	□	□
Ulcers	□	□	□
Jaundice	□	□	□
Constipation	□	□	□

Skin	Yes Now	Yes Past	No Never
Skin Rash	□	□	□
Lump/Growth on Skin	□	□	□
Boils	□	□	□
Persistent Itch	□	□	□
Change in Skin Color	□	□	□
Musculoskeletal			
Joint Pain	□	□	□
Neck Pain	□	□	□
Sore Muscles	□	□	□
Osteoporosis	□	□	□
Psychiatric			
Memory Loss/Forgetfulness	□	□	□
Depression	□	□	□
Respiratory			
Wheezing	□	□	□
Frequent Cough	□	□	□
Shortness of Breath	□	□	□
Blood in Sputum	□	□	□
Genitourinary			
Urine Retention	□	□	□
Painful Urination	□	□	□
Urinary Frequency	□	□	□
Blood in Urine	□	□	□
Discharge (penile or vaginal)	□	□	□
Hematologic/Lymphatic			
Swollen Glands	□	□	□
Enlarged Lymph Nodes	□	□	□
Blood Clotting Problems	□	□	□
Easy Bruising or Bleeding	□	□	□
Frequent Bleeding from Gums	□	□	□
Anemia	□	□	□
Endocrine			
Excessive/Increased Thirst	□	□	□
Heat/Cold Intolerance	□	□	□
Too Hot/Cold	□	□	□
Tired/Sluggish	□	□	□
GYN (females only)			
Symptomatic Hot Flashes	□	□	□
Symptomatic Vaginal Dryness	□	□	□
Difficulty Sleeping	□	□	□

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HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

Please let us know if you would like to authorize others to discuss your health or insurance and billing information with Pawleys Pediatrics and Adult Medicine. We will also need to know if you prefer a general message or a detailed message to be relayed.

Please check each section for anyone who you permit us to communication with on your behalf.

Name:_____ Date of Birth:_____

Parent or Guardian of Pediatric Patient_____ Relationship_____
Email_____ □ I do not wish to provide my e-mail address.
NOTE: We do NOT share your e-mail address. It is used solely for Patient Portal Medical Chart Access.

Pawleys Pediatrics and Adult Medicine is authorized to release protected Health information about the above named patient in the following manner and to the below identified persons.

Please tell us who you authorize Pawleys Pediatrics and Adult Medicine to communicate with by checking the appropriate boxes below. In the event that we cannot reach you over the phone, we want to leave as much or as little information as you wish. Please check all that apply.

Self/Patient_____ **Phone Number**_____
- ☐ General Medical with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Medical and/or test results ☐ Voicemail ☐ Text Message
- ☐ General Financial with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Financial with detailed information ☐ Voicemail ☐ Text Message

Spouse/Partner_____ Phone Number_____
- ☐ General Medical with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Medical and/or test results ☐ Voicemail ☐ Text Message
- ☐ General Financial with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Financial with detailed information ☐ Voicemail ☐ Text Message

Family Member_____ Phone Number_____
Specify Relation to Patient_____
- ☐ General Medical with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Medical and/or test results ☐ Voicemail ☐ Text Message
- ☐ General Financial with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Financial with detailed information ☐ Voicemail ☐ Text Message

Healthcare Proxy/POA_____ Phone Number_____
- ☐ General Medical with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Medical and/or test results ☐ Voicemail ☐ Text Message
- ☐ General Financial with call back number only ☐ Voicemail ☐ Text Message
- ☐ Detailed Financial with detailed information ☐ Voicemail ☐ Text Message

_____

Printed Patient Name **Date**

_____

Signature of Patient or **Personal Representative** *Description of Personal Representative's Authority (Attach necessary Documentation)

_____*(initial)* I acknowledge I have read the Notice of Privacy Practices and I have the right to revoke this authorization at any time.

_____CCM: Chronic Care Management services New CCM enrollment date_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand Georgetown Internists and Pediatricians dba Pawleys Pediatrics and Adult Medicine's Notice of Privacy Practices containing a description of the uses and disclosures of my health information. I further understand that the Notice of Privacy Practices may be updated at any time and that I may receive an updated copy by submitting a request in writing.

Printed Patient Name

Signature of Patient Date

If completed by patient's personal representative, please print name and sign below.

Printed Patient Personal Representative Name Relation to Patient

Signature of Patient Personal Representative Date

I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

For Georgetown Internists and Pediatricians dba Pawleys Pediatrics and Adult Medicine Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Georgetown Internists and Pediatricians dba Pawleys Pediatrics and Adult Medicine made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reason documented below:

- ☐ Patient or patient's personal representative refused to sign.
- ☐ Patient or patient's personal representative unable to sign.
- ☐ Other_____

Printed Employee Name

Signature of Employee Date

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FINANCIAL POLICY

Patient Responsibility: Patients are responsible for payment for all non-covered services according to insurance requirements. Patients are responsible for presenting current insurance information at the time of each visit and for understanding the provisions and limitations of their own insurance plan. The physicians neither know, nor can they adjust their billing according to what is or is not covered.

If Pawleys Pediatrics & Adult Medicine is a participating provider with the patient's insurance, the patient will be responsible for payment of any deductible and co-payment **prior to service**. **Pawleys Pediatrics & Adult Medicine** will accept assignment and transmit the insurance claim to the insurance company for the contracted fee. However, if the insurance company denies the charges or fails to pay any portion of the bill other than the contracted discount, the patient agrees to pay immediately.

If Pawleys Pediatrics & Adult Medicine is NOT a participating provider with the patient's insurance, the patient will be responsible for payment of all charges **in full at the time of service**. A copy of the information will be supplied to the patient for filing claims to their insurance company.

Newborns: Parents will be required to provide proof of insurance or Medicaid coverage no later than 30 days from date of birth or will be billed the entire amount of the bill.

Medicare: Pawleys Pediatrics & Adult Medicine accepts assignment of Medicare Benefits. Medicare patients are **responsible for payment** of their **deductible and 20% co-pay** as well as any non-covered services at the time of service. We do NOT bill patients for the 20% of the Medicare allowable. If you have a secondary plan, we will gladly provide you information as to how you will file your secondary claim for your own reimbursement. We DO NOT file secondary claims. Some secondary or supplemental plans have agreements with Medicare to automatically and electronically cross claims from Medicare to the secondary. Pawleys Pediatrics and Adult Medicine will accept payment of these crossed over claims with the patient's authorization.

Patient's or Authorized Person's Signature: The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier, when the provider of service or supplier accepts assignment of the claim.

Insured's or Authorized Person's Signature: The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider or service or supplier's office must be insurer specific. It may state that the authorization applies to all services until it is revoked.

Medicaid: Medicaid is a federal and state funded program designed to provide coverage of medically necessary services for individuals who meet minimum income criteria. This practice accepts Medicaid (if it is the primary carrier) as payment in full upon receipt of a valid Medicaid card. Medicaid reimburses at a discounted rate that does NOT cover our cost of providing services. Medicaid patients are responsible for non-covered services at the time of their visit Examples of non-covered services are routine physicals over the age of 18, employment physicals, pregnancy tests and in some cases circumcisions.

Third Party Claims Such As: Worker's compensation, Motor Vehicle Accident, Personal Injury: This practice does not file worker's compensation or any third party claims. We cannot file your health insurance when you have a work related injury, motor vehicle accident or personal injury at the fault of another. Work related injuries must be filed to worker's compensation. We are glad to provide care to our established patients who have experienced these types of situations, however, you will be required to pay for your services on the date of service and submit your charges to your employer, worker's compensation, motor vehicle insurance company or attorney for your own reimbursement. Health insurance will not pay for third party claims.

Discounts: If you are a member of an insurance plan that **Pawleys Pediatrics & Adult Medicine** participates with, your charges will be adjusted according to our contract with your insurance company. It is fraudulent for a medical practice to waive co-pay or co-share; therefore, all patients are expected to pay on the date of service.

Collection Policy: A payment plan is available for patients who make arrangements with our billing department to pay off hospital charges in a timely fashion. A written documented payment plan may be executed to keep accounts of patients, who have experienced a hospitalization in good standing. Accounts are considered up to date if a payment plan has been executed and regular monthly payments received on time. PPAM reserves the right to postpone treatment until your account is made current. We also reserve the right to dismiss the patient from the practice for outstanding balances.

Pawleys Pediatrics & Adult Medicine reserves the right to charge interest on accounts that are deemed past due. **Pawleys Pediatrics & Adult Medicine** reserves the right to turn any patient's delinquent account over to an attorney or collection agency if deemed in default of payment obligation or compliance with this policy and the patient/responsibility party may be liable for attorney fees and and/or court costs.

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RED FLAG RULE

Welcome to Pawleys Pediatrics and Adult Medicine. We appreciate your confidence in our physicians and staff. We look forward to a healthy and lasting relationship with you and/or your family.

When arriving for your first appointment, please be prepared to provide us with the following information: **Current photo identification card** as proof of ID and if we participate with your insurance company, we will need a copy of your **current insurance card.** Please be prepared to provide your insurance card at **each visit.**

In order to protect your privacy and identity, we will require proof as per the Federal Government's Red Flags Rule, stating a plan must be in place to ensure that each patient's identity is reasonably confirmed and protected. Therefore, we will require an updated driver's license or utility bill in order to make any change of address or insurance.

Should Pawleys Pediatrics and Adult Medicine have concerns about your PHI or Identity, we will notify the Patient/Parent/Insured/Responsible party or Guardian and proper government authorities. Should you become aware of identity theft, an affidavit available through our office should be completed and provided to any and all creditors informing them of the identity theft.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSE3D AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT.

All patients have the right to know that their Personal Health Information (PHI) remains confidential. The Privacy Rights and Practices of **Pawleys Pediatrics and Adult Medicine** were established to protect the healthcare information of our patients as required by Section 164.520 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. These guidelines restrict the release of your medical information for the purpose of treatment, payment, and healthcare operations. The following are examples of agencies or facilities to which your personal health information may be released in the course of your treatment:

Health Insurance Providers	Laboratory Testing Facilities
Physician Consults	Physical Therapies
Pharmacies	Hospitals
Surgical Facilities	Physician Intern Training

Other Uses of disclosures permitted or required by law:

- Public Health Activities
- Reporting Abuse, Neglect, or Domestic Violence
- Health Inspection Agencies
- Judicial Proceedings
- Law Enforcement Purposes
- Disclosures about Decedents (Coroner/Funeral Dir)
- Workers' Compensation
- Specialized Government Functions (Military or Veterans' Activities)
- Avert Serious Threat to Public Health or Safety

THE RELEASE OF HEALTHCARE INFORMATION TO ANY OTHER SOURCE IS PROHIBITED WITHOUT THE WRITTEN AUTHORIZATION OF THE PATIENT OR GUARDIAN.

As a patient or guardian, you have the right to:

- Request restrictions on certain uses and disclosures of your healthcare information;
- Inspect and request changes to your medical records;
- Obtain a copy of your medical record (Fee charged for copies);
- Find out what disclosures of your record have been made;
- Receive confidential communications;
- Ask questions about your Privacy Policy; and
- File a complaint with Pawleys Pediatrics and Adult Medicine, or secretary of Health and Human Services without the fear of any reprisal, if you believe your privacy rights have been violated.

Pawleys Pediatrics and Adult Medicine is required by law to abide by the terms outlined in this notice. Pawleys Pediatrics and Adult Medicine reserves the right to change the terms of the Privacy Notice and make the new provisions effective for all protected health information that we maintain. Any revisions of this notice will be posted and distributed during office appointments.

If you need help reading or understanding this form, please tell the Receptionist.

I. Notice of deemed consent to HIV blood testing Should an employee be exposed to my blood/ body fluids in a way that might allow transmission of infection due to blood borne disease (eg, HIV, Hepatitis B, etc.) or other communicable diseases, then I understand that ACCORDING TO SC STATE LAW, for the safety, health and possible treatment of our employees, samples of my blood or body fluid may be tested for evidence of infection.

I also understand that dba Pawleys pediatrics and Adult Medicine employees and physician(s) are not obligated to submit to blood tests for certain infectious diseases (eg, HIV, Hepatitis B, etc.) if I am inadvertently exposed to their blood or body fluid during the course of my treatment in the hospital or office.

II. Release of Medical Information or related data:
"I hereby authorize dba Pawleys Pediatrics and Adult Medicine to release or to re-release from any physician, his/her office, or any other medical facility information necessary for referral purposes." This authorization shall remain in force until written notice is giveN from the patient or responsible person.

III. General consent for treatment. " I hereby authorized the physicians of dba Pawleys Pediatrics and Adult Medicine, his/her staff to perform and do hereby consent to such medical treatment as he/she feels is necessary, including diagnosis procedures, medical examinations and treatment as may, in his/her opinion, be medically necessary. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of any procedure, treatment or examination.

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PEDIATRICS AUTHORIZATION FORM

Patient EMR Account Number_____

Patient Name:_____ Date of Birth:_____

Father's Name:_____ Date of Birth:_____

Mother's Name:_____ Date of Birth:_____

Legal Guardian's Name:_____ Date of Birth:_____

I,_____, hereby give permission for the following adults to have my child,_____ , evaluated and /or treated by any physician of Pawleys Pediatrics & Adult Medicine. Treatment may include but is not limited to injections, immunization, breathing treatments, wound/laceration repair. I am aware that it will be the responsibility of the person having my child evaluated to provide payment on the date of service as indicated by the policies of the medical practice and my insurance company and that services may not be billed on a later date. I understand that for my child's protection, he/she may not be seen if the adult escorting them to the medical office is not listed below. This authorization will remain in effect until such point I notify Pawleys Pediatrics and Adult Medicine in writing of any changes.

Name:_____ Relation to Patient:_____

Name:_____ Relation to Patient:_____

Name:_____ Relation to Patient:_____

Name:_____ Relation to Patient:_____

Name:_____ Relation to Patient:_____

_____

Printed Parent or Legal Guardian Name

_____

Signature of Parent or Legal Guardian Date

_____

Printed Witness Name

_____

Signature of Witness Date

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PEDIATRICS HISTORY FORM

Patient Name_____ Date of Birth_____

Birth Place_____ Pregnancy issues_____

Birth Weight_____ Term_____ Preterm Weeks_____ Apgars (If known)_____

Newborn problems_____ Days in hospital _____

Breast feeding_____ Formula_____ Solids introduced at what age_____

Feeding problems_____

Other hospitalization(s)_____

Medical problems_____

Growth: □ Normal □ Delayed □ Past Problems_____

Developmental: □Normal □Delayed □Fast Problems_____

Was Hepatitis B immunization received at birth?_____ Date_____

Immunization issues_____

Any known allergies?_____

Family History:

Father's Date of Birth_____

Mother's Date of Birth_____

Siblings: Boy(s) Date of Birth_____

Girl(s) Date of Birth_____

Adopted_____ Twins_____

□ Cancer_____ □ Asthma_____ □ Muscle Disease_____

□ Sickle Cell_____ □ Diabetes_____ □ Inherited Disease_____

□ High Blood pressure_____ □ Eczema_____ □ Arthritis_____

□ Heart Attack (Specify Age)_____ □ Anemia_____

□ Stroke (Specify Age)_____ □ Crib Death_____

□ Bleeders_____ □ Epilepsy (Seizures)_____ □ Kidney Disease_____

□ Other_____

_____

Printed Parent or Legal Guardian Name

_____

Signature of Parent or Legal Guardian Date

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Below option required

□ **Expires upon one time release** □ **Expires by written request only**

I authorize_____ Phone_____ Fax_____
to release requested medical information regarding:
Patient Name_____ **DOB**_____

Address_____ Phone_____

City_____ State_____ Zip_____ SSN_____

Covering the period(s) of treatment from_____ to_____

Per my request, the following information may be released: (check below)

□ Entire Medical Record	□ Radiology Reports	□ Pathology Reports
□ History and Physical	□ Operative Reports	□ Consultation Reports
□ Discharge Summary	□ Laboratory Reports	□ Progress Notes
□ Immunization Record	□ Other (please specify)_____	

Type of Access Requested: □ Copies of the record □ On-site record review by patient

Purpose of Disclosure: □ Transfer of Primary Care to_____

□ Personal Use □ Insurance □ Continuity of Care □ Legal □ School / Daycare □ DSS
□ Foster Care □ Subpoena □ Other (please specify)_____

Note: Over the counter or personal use *fees* are payable in advance with *cash or certified check and picture ID.*

Entity or person who will receive the requested information:

Name_____ Phone_____

Address_____ Fax_____

City_____ State_____ Zip_____

How you want to receive the requested information: (check below)

□ Pick up □ Mail □ Fax □ Email (***must have additional email encryption waiver signed***)

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that released information may include a communicable disease diagnosis such as HIV.

Signature_____

Patient/Parent/Guardian Relationship Date

Office Use Only: □ Confirmation of signature of relationship to patient
□ Confirmation of signature on file
□ Power of Attorney or Legal Documentation Attached