Endocrinology Clinics of Texas, P.A.
7500 Beechnut Suite 252, Texas 77074

## Welcome to Endocrinology Clinics of Texas, P.A.

We appreciate the opportunity to participate in your healthcare. We provide specialized care in the areas of thyroid disease, osteoporosis and bone disorders, non-surgical reproductive endocrinological disorders such as polycystic ovary syndrome (PCOS) and male testicular dysfunction and evaluation of infertility. We also diagnose and manage a variety of other endocrine disorders.

We look forward to seeing you at our clinic. Please take the following steps and bring the necessary forms to ensure that we are prepared for your visit and can most optimally meet your needs. We encourage you to check our website from time to time for updates.

- Please confirm with your referring physician that a request for your consultation and all related medical records have been sent.
- Bring your insurance card and identification card (driver's license, passport, etc.).
- Bring a form of co-payment with you. We accept cash, check, and major credit cards.
- If your insurance requires, please be prepared to apply payment towards your deductible.
- Please bring a list of all your current medications (name and doses) or the bottles of your current prescriptions including non-prescription medications such as herbal remedies and vitamins.
- Please complete and bring the required forms.
- If you have diabetes, please ensure that we have an estimate of your recent hemoglobin A1c levels (HbA1C), and please bring your meter.

Tel: (281) 779-4243 Fax: (281) 779-4245
www.endoclincstx.com

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**PATIENT INFORMATION** **Date**: _____

**Last Name**: _____ **First Name**: _____

**Middle Name**: _____

**Home Number**: _____ Cell **Number**: _____

**E-mail Address**: _____

**Address:** _____
**Street** **City** **State** **Zip**

**Date of Birth:** _____ **Social Security Number:** _____

**Marital Status:** _____ **Gender:** ____ **Male** ____**Female**

**Employer:** _____

**Occupation:** _____

## List of Emergency Contact SPOUSE/PARTNER/SON/DAUGHTER (circle one)

**Name:** _____ **Contact Phone:** _____

## SPOUSE/PARTNER/GUARDIAN INFORMATION (circle one)

Name: Last _____ First _____ Middle _____

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail Address _____

Address (if Different from above):

_____
Street City State Zip

Date of Birth: _____
Employer: _____

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## INSURANCE INFORMATION

### How do you intend to pay for your visit?

**_____Cash ____Check ____Credit Card ____Insurance**

### Primary Health Insurance:

**Insurance Company: _____**
**Mailing Address: _____**
**Policy or ID Number: _____ Group Number: _____**
**Insured Name: _____ Relationship to insured: _____**

### Secondary Health Insurance:

**Insurance Company: _____**
**Mailing Address: _____**
**Policy or ID Number: _____ Group Number: _____**
**Insured Name: _____ Relationship to insured: _____**

### Preferred Pharmacy information including address (or location) and phone #

**Mail order Pharmacy (if applicable): _____**
**Local Pharmacy name and phone #: _____**
**Primary Care Doctor/OBGYN:**

_____

Name Phone Number

**ASSIGNMENT OF INSURANCE BENEFITS: The undersigned herby authorizes the release of any medical or other information necessary to process this claim. I also request payment of government benefits to Endocrinology Clinics of Texas, P.A. I furthermore authorize payment of medical benefits to Endocrinology Clinics of Texas, P.A. for services rendered to myself or to my minor child or for those whom I have guardianship or Power of Attorney for.**

_____ _____

Signature of patient or responsible party Printed Name.

Endocrinology Clinics of Texas, P.A.
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Patient Name: _____Date: _____

Date of Birth: _____

Main Concern(s)/Reason for visit today: _____

ALLERGIES (Please include type of reaction to each allergy listed):

_____

_____

_____

Current Medications (Both prescription and over the counter including Herbal, Vitamins, etc.)
Please include another page if needed. Disregard if you maintain a separate list. Please bring your list.

NAME OF MEDICATIONS AND THEIR DOSES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

CURRENT MEDICAL CONDITON:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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PREVIOUS MEDICAL PROBLEMS OR HOSPITALIZATIONS, SURGERIES, PROCEDURES:
(Please include dates):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

FAMILY HISTORY (List any health problems of your closely related family members):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

**PERSONAL AND SOCIAL HISTORY**

OCCUPATION: _____

Smoking: ____ Current ____ Ex-smoker ____ Lifetime non-smoker
If a current or an ex-smoker, number of packs of cigarettes per day smoked: _____
Number of years smoked (add up all the years and discount the breaks if any): _____
If an ex-smoker, when did you quit (year): _____
Do you consume alcoholic beverages? ____ YES ____NO
If "yes" how much? _____
Do you exercise"? _____YES ____ NO
If yes, average duration of each session: _____; Number of sessions/weeks: _____
Types of exercise activities: _____

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## REVIEW OF SYSTEMS

Check if any of these apply. Feel free to annotate on this page or a separate sheet if you would like to elaborate or clarify.

Weight: _____ gain How much did you gain? _____ lbs; over what period? _____
_____ loss How much did you loss? _____ lbs; over what period? _____

| | | | |
|---|---|---|---|
| Appetite: | _____ Increased | _____ Decreased | _____ Normal |
| Thirst: | _____ Increased | _____ Decreased | _____ Normal |
| Fatigue: | _____ Yes | _____ No | |
| Fever: | _____ Yes | _____ No | |

| | | |
|---|---|---|
| **SKIN** | _____ Excessively Dry | _____ Excessively Moist |
| Change in skin color | _____ Yes | _____ No |
| Easy Bruising | _____ Yes | _____ No |
| New stretch marks | _____ Yes | _____ No |
| Skin Rash | _____ Yes | _____ No |
| Acne | _____ Yes | _____ No |
| Excessive body hair growth | _____ Yes | _____ No |
| Scalp Hair loss | _____ Yes | _____ No |
| Do you feel unusually hot or cold? | _____ Yes | _____ No |

| | | |
|---|---|---|
| **EYES** | | |
| Change in appearance | _____ Yes | _____ No |
| Loss of vision | _____ Yes | _____ No |
| Blurry vision | _____ Yes | _____ No |
| Double vision | _____ Yes | _____ No |

| | | |
|---|---|---|
| **HEAD, NOSE, THROAT** | | |
| Headache | _____ Yes | _____ No |
| Change in hat/head size | _____ Yes | _____ No |
| Change in dental bite | _____ Yes | _____ No |
| Inability to smell | _____ Yes | _____ No |
| Hoarseness of voice | _____ Yes | _____ No |
| Difficulty to swallow | _____ Yes | _____ No |
| Lump in neck | _____ Yes | _____ No |
| Snoring | _____ Yes | _____ No |

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**BREAST**

| | | | |
|---|---|---|---|
| Pain | | _____ Yes | _____ No |
| Lump | | _____ Yes | _____ No |
| Discharge | ____ Milky | _____Bloody | _____ Clear |

**CHEST**

| | | |
|---|---|---|
| Chest pain or discomfort | _____ Yes | _____ No |
| Difficulty breathing | _____ Yes | _____ No |
| Palpitations | _____ Yes | _____ No |

**ABDOMEN**

| | | |
|---|---|---|
| Diarrhea | _____ Yes | _____ No |
| Pain | _____ Yes | _____ No |
| Constipation | _____ Yes | _____ No |
| Nausea | _____ Yes | _____ No |
| Vomiting | _____ Yes | _____ No |
| Peptic ulcers | _____ Yes | _____ No |

**KIDNEY AND GENITAL SYSTEM**

| | | |
|---|---|---|
| Excessive urination | _____ Yes | _____ No |
| Pain on urination | _____ Yes | _____ No |
| Blood in urine | _____ Yes | _____ No |
| Kidney stones | _____ Yes | _____ No |
| Decrease in libido | _____ Yes | _____ No |
| Difficulty in erections (men) | _____ Yes | _____ No |
| Abnormal menses (women) | _____ Yes | _____ No |
| Excessive bleeding during menses | _____ Yes | _____ No |
| Reduced blood loss during menses | _____ Yes | _____ No |
| Are you pregnant? | _____ Yes | _____ No |
| Last menstrual period? | _____ | |

**MUSCLE** _____ Cramps _____ Weakness _____Aches

**BONES AND EXTREMITIES** _____ Change in hands or feet size _____ Fractures
_____ Bone pain _____ Joint pain _____ Calf pain on walking or running.

**BLOOD DISORDERS**

| | | |
|---|---|---|
| Do you have anemia? | _____ Yes | _____ No |

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## PATIENT RECORD OF DISCLOSURES

HIPAA Privacy Law gives individuals the right to determine who and how one would like to receive protected health information (PHI). The individual can decide the method of preferred communication of confidential information and restrict the use of certain other forms of communication. For instance, you could choose to have your medical information communicated to you through your cell phone rather than the home phone. This form will help the healthcare provider determine what method of communication should be used for the transmission of PHI. It is also your responsibility to ensure that our offices have the most current contact information.

Number where it is OK to leave a detailed message on.

_____

Patient Signature: _____ Date: _____

Print Name: _____ Birth date: _____

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## CONDITIONS OF TREATMENT

Patient Name: _____ Date of Birth: _____

I. Insurance Verification and/or Pre-Authorization – Many insurance companies require pre-authorization for various procedures. Endocrinology Clinics of Texas P.A. will assist the patient in obtaining the necessary pre-authorizations when needed, but it is ultimately the patient's responsibility to determine if your insurance company requires this. Failure to obtain necessary pre-authorization or second opinions may result in a reduction or rejection of benefits by the insurance company.
II. Assignment of Insurance Benefits-I hereby authorize my insurance company to pay Endocrinology Clinics of Texas P.A directly. I understand that I am responsible for charges not covered by my insurance company including late penalty charges. I agree that a photocopy of this authorization is as effective as the original.
III. Confidentiality-Confidential information expressly identifies the medical nature of the service rendered to a patient, and includes all information and records obtained in the course of treatment. It includes information from history and physician examination, diagnosis, treatment rendered, laboratory and radiology results, progress notes, and miscellaneous medical reports.
IV. Medicare authorization: Patient's certification authorization to release information and payment request–I certify that the information given in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient named above to release such information to the Social Security Administration or its intermediaries or carriers, effective from (today's date) _____forward.
V. Authorization for disclosure of Information for Purpose of Service Reimbursement –I hereby authorize Endocrinology Clinics of Texas P.A. to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release Endocrinology Clinics of Texas P.A. from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing.
VI. Financial Agreement-I understand that inconsideration of the services rendered, I am obligated to pay Endocrinology Clinics of Texas, P.A. in accordance with its regular rates, terms, or contractual agreements. I understand that I am responsible for any service "not covered" by insurance and that the obligation to pay for medical services may not be deferred for any reason. If the account is referred to any agency for collection, I agree to pay all collection expenses.
VII. I have read and understand this financial agreement. I have had an opportunity to ask questions and, at my request, received a copy of my signed form. I accept the responsibility of its terms.

Patient's Signature: _____ Date: _____

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www.endoclincstx.com

# Privacy Notice (HIPAA)

**IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Endocrinology clinics of Texas, P. A. is required by law to protect certain aspects of your health care information known as Protected Health Information of PHI and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know how Endocrinology clinics of Texas, P. A. is permitted to

1. Use and disclose PHI about you
2. How you can access and copy that information
3. How you may request amendment of that information
4. How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.
We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff is committed to following at all times.

PLEASE READ THE FOLLOWING DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT PLEASE CONTACT HIPAA Privacy Officer listed below and someone will contact you.

Shikha Bharaktiya, MD/Andres Splenser, MD
Endocrinology Clinics of Texas, P.A
7500 Beechnut St Suite 252
Houston TX 77074
Tel: (281)-779-4243
Fax: (281)-779-4245

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

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Endocrinology Clinics of Texas, P. A. is permitted to use and disclose Protected health Information (PHI) about you.

Uses and disclosures of Phi: Endocrinology Clinics of Texas, P. A. may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.

Examples of our use of your PHI:

**For treatment:** This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who gave orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

**For payment:** This includes any activities we must undertake in order to get reimbursed for the service we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

**For health care operations:** This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances, and complaints, creating reports that do not individually identify you for data collection purposes.

**Use and Disclosure of PHI without your authorization:** Endocrinology Clinics of Texas, P. A. is permitted to use PHI without your written authorization, or opportunity to object in certain situations including:

1. For Endocrinology clinics of Texas, P. A.'s use in treating you or in obtaining payment for services provided to you or in other health care operations;

2. For the treatment activities of another health care provider;

3. To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);

4. To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;

5. For healthcare fraud and abuse detection or for activities related to compliance with the law;

6. To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or is we give you an opportunity to object such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situation where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment determine that was disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;

7. To a public health authority in certain situation (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law);

8. For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;

9. For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;

10. For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime; For military, national defense and security and other special government functions;

11. To avert a serious threat to the health and safety of a person or the public at large;

12. For workers' compensation purposes, and in compliance with corkers' compensation laws;

13. To coroners, medical examiners, and funeral directors for identifying a decreased person, determining cause of death, or carrying on their duties as authorized by law;

14. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or t an organ donation bank, as necessary to facilitate organ donations and transportation;

15. For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;

16. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.

**Patients Rights:** As a patient, you have a number of rights with respect to the protection of your PHI, including:

1. **The right to access copy or inspect your PHI**: This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials, we have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed at the end of this Notice.

2. **The right to amend your PHI of the right to request amending your PHI**: You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request will be denied. If you wish to request that we amend the medical information that we have about you, you should contact in writing the primacy officer listed at the end of this Notice.

3. **The right to request an accounting of our use and disclosure of your PHI**: You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request.

We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment, or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

4. **The right to request that we restrict the uses and disclosures of your PHI**: You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment, or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. Endocrinology Clinics of Texas, P. A. are binding on Endocrinology Clinics of Texas, P. A.

**Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request:** If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

**Revisions to the Notice:** Endocrinology clinics of Texas, P. A. reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting the Privacy Officer identified below.

**Your Legal Rights and complaints:** You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government. Should you have any questions, comments or complaints you may direct all inquiries to the privacy officer listed at the end of this Notice. Individuals will not be retaliated against for filing a complaint.

If you have any questions of if you wish to file a complaint or exercise any rights listed in the Notice, Please Contact **HIPAA Privacy Officer** listed below:

Shikha Bharaktiya, MD/Andres Splenser, MD
Endocrinology Clinics of Texas, P.A
7500 Beechnut St Suite 252
Houston, Texas 77074
(281) 779-4243

Endocrinology Clinics of Texas, P.A.
7500 Beechnut Suite 252, Texas 77074

## PRIVACY NOTICE SIGNATURE FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name: _____ Date: _____

Print Name of Authorized Representative (if applicable):

_____

Signature of Patient or Authorized Representative:

_____

Date: _____

Comments of Endocrinology Clinics of Texas, P. A. regarding why a written acknowledgement was not obtained:

_____

_____

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## CO-PAY and DEDUCTIBLE POLICY

We ask that all office visits and services be paid for the time they are provided. The exceptions to this are patients covered by companies with whom we have signed participation agreements. If your insurance is an HMO, you are required to obtain an authorization from your referring healthcare provider before we can see you. This would allow us to see you during a specific time period and for a specific number of visits. It is extremely important that we know this information before your appointment. We will make every effort to help you with this. If we do not have an authorization at the time of your visit, you will be asked to sign a waiver; **your appointment will be rescheduled**. Please come prepared to pay your co-pay whenever you are seen.

For non-HMO insurances with whom we participate, please come prepared to pay your co-payment and deductibles. Arrangements can be made when expenses require installment payments.

I have read and understand this policy and accept the responsibility of its terms.

Patient Signature: _____ Date: _____

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# LATE ARRIVAL AND NO-SHOW POLICY

Patient Name_____

Date of Birth_____

We, at Endocrinology Clinics of Texas, PA strive to provide high quality health care to all of our clients in a timely manner. Failure to keep scheduled appointments is costly not only to the clinic but also to you as a patient. Late arrivals beyond 15 minutes of your expected appointment can cause significant inconvenience not only to the healthcare providers, but also to other patients.

New patients, we routinely recommend that you plan to arrive at least 30 minutes in advance of your first visit if you have not had a chance to complete the paperwork from our website.

Late arrivals defined as arrivals 15 minutes past the scheduled appointment will need to be re-scheduled. However, depending on the workflow of the clinic, we may or may not be able to accommodate you. This can only be determined by the clinic staff after your arrival.

Patients who are unable to keep their appointments are requested to give 48 hour notice prior to their appointment. We realize it is not always possible to provide this notice and we will consider this on a case by case basis. Providing such notice allows the clinic time to offer other patients the opportunity to see our providers, thus using the clinic time more efficiently.

If an established patient fails to provide notice 48 hours prior to the appointment, it will be necessary to charge a $50.00 fee that will be billed to his/her account.

If a patient fails to keep 3 appointments, he/she will be considered dismissed from the practice, and a letter of dismissal will follow.

I have read and understood this policy and accept the responsibility of its terms.

Patient Signature _____ Date_____

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## Acknowledgement of Office Policies

**Please review and initial**

Patient Record of disclosure _____

Privacy Notice Signature Form _____

Conditions of Treatment _____

Co-Pay and Deductible Policy _____

Past due balances will need to be _____
Paid in full prior to next follow up visit

Notification of new Insurance/Change in Policy: (We must receive new information 72hrs before office visit to verify benefits. Otherwise OV/Lab payment will be due in full day of visit, claim will be filed and reimbursement due will be made to patient afterwards)

_____

Late Arrival and No Show/Call Policy _____

Demographics UP to Date _____

Prescription/Refill request: (We must receive your request 72 hours before exhausting your medications)

_____

CPL/Quest statement inquiries: (patient will call insurance and laboratory for any clarification prior to calling office for any questions)

_____

*NOTE: This will be kept in your record for future reference*

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## AUTHORIZATION TO RECEIVE MEDICAL RECORDS/INFORMATION

Patient's Name: _____Date of Birth: _____

Address: _____State: _____Zip Code: _____

Social Security #: _____Phone#: _____

I authorize the release of my medical records by the organization or physician listed below:

Physician's Name: _____

Physician's Address: _____

Physician's Phone #: _____ Fax # of Physician: _____

Reason for Records Release: _____

To furnish a copy of medical records on the patient named above for the period of

Beginning date: _____ to Ending date: _____

| | | |
|---|---|---|
| ____ All available records | _____ Office visits & progress notes | _____ Admissions H&P |
| _____ Laboratory values | _____Consultation reports | _____ Discharge summary |
| _____ X-RAY and Scan reports | _____ Bone density | _____ Surgical Pathology |
| _____EKGs | _____ Operative/Procedure notes | |

Other: _____

I authorize release of all information, including information regarding HIV testing, substance abuse and psychological disorders that may be included in the medical record. I hereby release your physician and employees and facility from liability form following this authorization and release.

Patients Signature: _____ Date: _____

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