NEW PATIENT INTAKE FORM

***Welcome.*** *It is our sincere desire to provide you with quality, comprehensive health care. To these ends it is important we gather a detailed picture of your health and health related issues. Please complete this form thoroughly, legibly, and accurately. The final page has space for further details you may wish to include. Thank you!*

***PATIENT INFORMATION- DATE: \_\_\_\_\_\_\_\_\_***

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nickname/ preferred name if different from above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: S M D W Sex: M F Social security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Decline response

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PATIENT CONTACT INFORMATION-***

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_ Preferred phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave detailed messages at this phone? No Yes

Secondary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION-** *please complete if you did not bring your insurance card*

Name of responsible party if other than patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D. O. B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company name and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***EMERGENCY CONTACT INFORMATION-***

|  |  |  |
| --- | --- | --- |
| Name: | Relationship: | Phone number: |
|  |  |  |
|  |  |  |
|  |  |  |

*I hereby authorize Patient’s Clinic, INC to discuss and/ or release my protected health information to:* ***Myself only***

|  |  |  |
| --- | --- | --- |
| Name:  | Relationship*:*  | Phone*:*  |
|  |  |  |
|  |  |  |
|  |  |  |

**ADVANCE CARE DIRECTIVE-** Do you have an advance directive or living will? No Yes

Do you have a Durable Power of Attorney? No Yes If yes please enter information below

|  |  |  |
| --- | --- | --- |
| Name:  | Relationship:  | Phone:  |
|  |  |  |

**SPECIALISTS CONTACT INFORMATION-**

Name Office phone Location

|  |  |  |
| --- | --- | --- |
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**WELLNESS SCREENING-**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date:  | Location:  | Result:  |
| Colonoscopy |  |  |  |
| Cologuard |  |  |  |
| Mammogram |  |  |  |
| DEXA (bone density) |  |  |  |
| Pap smear |  |  |  |
| PSA |  |  |  |
| Full body skin cancer exam |  |  |  |
| Diabetic Eye Exam |  |  |  |
| Hepatitis C Screening  |  |  |  |
| Flu Vaccine  |  |  |  |
| Tetanus vaccine |  |  |  |
| Zoster vaccine |  |  |  |
| Shingrix |  |  |  |
| Pneumonia Vaccine |  |  |  |

***Reason for today’s visit:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of systems:** In each area, if you are not having any difficulties, please check “No Problems”. If you are experiencing any of the symptoms listed, please **CIRCLE** the ones that apply, or explain any that may not be listed. If you have any questions about this, please ask the nurse or your provider.

**Const. (health in general)** No Problems, lack of energy, unexplained weight loss or weight gain, loss of appetite, fever, night sweats, fever, pain in jaw when eating. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears, nose, mouth, & throat** No Problems, difficulty with hearing, sinus problems, runny nose, Postnasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C-V** **(Heart & Blood vessels)** No Problems, irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Resp. (Lungs & Breathing)** No Problems, shortness of breath, prolonged cough, wheezing, speed and production, prior tuberculosis, pleurisy, use of oxygen at home, coughing up blood, abnormal chest x-ray. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GI (Stomach & Intestines)** No Problems, heartburn, constipation, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GU (Kidney & Bladder)** No Problems, painful urination, frequent urination, urgency, prostate problems, bladder problems, frequent kidney infections or UTIs, impotence, vaginal discharge or sores. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MS (Muscles, Bones, Joints)** No Problems, Joint pain, aching muscles, shoulder pain, knee pain, swelling of joints, joint deformities, back pain. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Integ. (Skin, Hair, & Breast)** No Problem, persistent or new rash, itching, new skin lesion, changing existing skin lesion, hair loss or increase, breast changes. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurologic (Brain & Nerves)** No Problems, frequent headaches, double vision, blurred vision, weakness, changing sensation, problems with walking her balance, dizziness, Tremor, loss of consciousness, uncontrolled emotions, episodes of visual loss, numbness or tingling. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric (Mood & Thinking)** No Problems, insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Endocrinologic** No Problems, intolerance to heat or cold, menstrual irregularities, changes in sex drive, frequent hunger/urination/thirst. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hematologic (Blood/Lymph)** No Problems, easy bruising, easy bleeding, anemia, abnormal blood test, leukemia, unexplained swollen areas. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergic/ Immunologic** No Problems, seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past medical history:**

Please review the list below and check any problems you have no or have had in the past.

Please list any other medical illness or conditions and provide details as necessary.

|  |  |
| --- | --- |
| Abnormal pap smear |  |
| ADD/ADHD |  |
| Alcoholism |  |
| Anemia |  |
| Aneurysm (where) |  |
| Anxiety |  |
| Arthritis |  |
| Asthma |  |
| Atrial Fibrillation |  |
| Bipolar disorder |  |
| Blood clot |  |
| Blood transfusion |  |
| Cancer (what kind) |  |
| Chronic bronchitis |  |
| COPD |  |
| Congestive heart failure |  |
| Crohn’s disease or IBS |  |
| Depression |  |
| Diabetes |  |
| Emphysema |  |

|  |  |
| --- | --- |
| Seizures |  |
| Sexually transmitted disease |  |
| Skin disorder |  |
| Stomach ulcers |  |
| Stroke |  |
| Visual disorder |  |
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| Frequent infections |  |
| GERD |  |
| Gout |  |
| Headaches |  |
| Hearing loss |  |
| Heart attack |  |
| Hepatitis (A, B, or C) |  |
| High blood pressure |  |
| Hight cholesterol |  |
| Hyperthyroidism |  |
| Hypothyroidism |  |
| Insomnia |  |
| Kidney disease |  |
| Obstructive sleep apnea |  |
| Osteoporosis |  |
| Prostate problems |  |
| Psoriasis |  |
| Rheumatoid arthritis |  |
| Seasonal allergies |  |

**Please list all past surgeries and hospitalizations and the approximate dates:**

|  |  |  |
| --- | --- | --- |
| Procedure  | Date | Hospital |
|  |  |  |
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**Over the past two weeks, how often have you been bothered by any of the following?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all- 0 | Several days- 1 | Half the days- 2 | Nearly every day- 3 |
| Little interest/ pleasure in doing things |  |  |  |  |
| Feeling depressed or hopeless |  |  |  |  |

If **65 years or older** please answer the following:

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Have you felt unsteady or fallen more than once in the past year? |  |  |
| Can you switch a light on/off easily from your bed without fear of falling? |  |  |
| Are the floors and walkways in your home safe and in good repair? |  |  |
| Is the lighting in your home sufficient for you to see safely? |  |  |
| Is it difficult to get out of bed or off a chair or toilet without assistance? |  |  |

**Current Medications**: please include all OTC and supplements

|  |  |  |
| --- | --- | --- |
| **Drug name:** | **Dose:** | **How often?** |
|  |  |  |
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**Allergies**: (medications, food, animals, etc) please also list what type of reaction you have associated with the allergy:

|  |  |
| --- | --- |
| Allergy | Reaction |
|  |  |
|  |  |
|  |  |

**Family history:**

|  |  |  |  |
| --- | --- | --- | --- |
| Relative | Condition/ description | Living? | If deceased at what age? |
| Mother |  |  Y N |  |
| Father |  |  Y N |  |
| Sibling |  |  Y N |  |
| Other: |  |  Y N |  |

**Social history:**

Do you currently smoke? **Y N** if no, did you previously? **Y N**

Years smoked\_\_\_\_\_\_\_\_\_\_\_\_ Packs/Day\_\_\_\_\_\_\_\_\_\_\_\_ how long ago did you quit\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any other tobacco products? **Y N** Consume alcohol? **Y N**

If yes, drinks/week\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? **Y N** previous pregnancies? **Y N**

If yes please list the year(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payments for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to Patient’s Clinic, INC for services rendered. I authorize representatives of Patient’s Clinic, INC to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Failure to pay overdue bills of 120+ days may be sent to collections. If this occurs, there will be a collection fee of $55.00 added to your existing balance.

Co-payments and self-pay payments must be paid in full at the time of service. No exceptions.

We accept cash, checks, credit and debt cards. Returned checks will accumulate an additional $25 fee.

***I read and agree to the above.***

Patient or legal guardian name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or legal guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_

**Patient’s Clinic Office Policies**

It is our mission to efficiently deliver high- quality, comprehensive medical care to you- our valued patient. To achieve this goal, we request all patients adhere to the following administrative policies. Your cooperation is greatly appreciated.

Fee Policies

1. If you cannot keep an appointment, you are responsible for notifying the office a minimum of 24 hours in advance.

Fee for a missed appointment without a minimum of 24 hours………………………………….……..$25.00

1. FORMS- completion of health forms requiring physician signature…………fee based on complexity
2. Copying of your medical record upon your signed request…….per page fee- not to exceed $40.00

Medication refills

* Please request your medication refills at the time of your visits. This provides the most timely refill service.
* Allow 2 business days to process requests made by phone or patient portal email.
* Please note: medications ordered elsewhere (ie specialist) must be refilled by the original ordering physician unless approved by your provider

Test results

* Lab testing can take 2-14 days to process depending on tests ordered. You will be contacted regarding results within 48 hours of receipt of test results ordered by our providers.
* Lab results ordered by our providers can be viewed through your online patient portal. Mail copies of test results are available directly from the lab upon your request to them. We do not mail test results. You may also pick-up test results directly from our office in person.
* Abnormal test results ordered by our office will be discussed in our office directly. We do not discuss abnormal test results over the phone as a treatment plan will also need to be discussed. This is the best way to ensure our patients understand the results.

***I have read and agree to all above policies.***

Patient’s name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release Medical Information**

Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

The above listed patient authorizes the release of the following protected health information from:

 Facility name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Office notes The purpose of this request is:
* Pathology/ Radiology reports continuation of care
* Laboratory reports insurance change
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Entire medical record

Please send my medical information to: Name: \_\_\_\_\_\_\_\_\_\_\_**Patient’s Clinic, INC**\_\_\_\_\_\_\_\_\_\_\_\_

 Address: \_\_\_\_\_\_\_\_\_**709 McFarland Street**\_\_\_\_\_\_\_\_\_\_\_

 City, state, zip: \_\_\_\_**Morristown, TN 37814**\_\_\_\_\_\_\_\_\_\_\_

 Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_**423- 464- 4120**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that:

* By signing this form, I am authorizing the use or disclosure of protected health information as indicated above
* I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
* I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation.
* If the receiving party is not subject to medical records privacy laws, the information may be redisclosed by the recipient and may no longer be protected by federal or state law. Patient’s Clinic shall not be held liable for any consequences resulting from redisclosure.
* If the information to be released contains any information about HIV/AIDS and additional HIPAA release of medical information may be requested.
* Alcohol or substance abuse, mental health, or psychiatry notes may have additional compliance requirements that may need to be met before the information can be released.
* Patient’s Clinic may charge an administrative fee to cover the cost of labor, copying, and postage if necessary. This office will inform me of any charges and arrange for these payments.
* This authorization will expire one year from completion date.

Patient/ Guardian Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/ Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_