«PcpFName» «PcpLName», «PcpInitials»
«RendPrMailingAddr1», «RendPrMailingAddr2»
Phone: «RendPrPhone» | Fax: «RendPrFax» |
www.sjchs.org

January 31, 2022

«FirstName» «LastName»
«MailingAddress1»
«PtAddress2»
«PtCityStateZip»

Dear New Patient,

We at St. Joseph's/Candler Physician Network wish to take a moment to welcome you to our practice!

We want you to know that we appreciate the opportunity to take care of your healthcare needs, and we look forward to serving you. Your health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We offer a wide variety of services and preventive programs to address your physical wellbeing.

Our medical practice specializes in the provision of primary care services, if you have a condition that requires specialized treatment (pain management, Adult Attention Deficit Disorder, etc.) we will be happy to recommend a specialist qualified to treat these specific conditions.

In order to expedite the new patient registration process, we ask that you complete the enclosed new patient forms and bring with you to your appointment. Please **do not** mail forms to the practice. Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office, and ensures we have the information necessary to fully address your healthcare needs.

In addition, please bring the following items with you:

- A photo ID
- Your insurance card(s)
- Your copayment (if required by your plan)
- A complete list of all medications you are currently taking

Should you need to reschedule or cancel your appointment, please call us at least twenty-four hours in advance at **«PcpPhone»** to allow us the courtesy of offering your spot to another patient.

Thank you for choosing St. Joseph's/Candler Physician Network for your healthcare needs!

St. Joseph's/Candler | Physician Network

Patient Registration

Patient Demographics

Last Name	First Name	M	Nickname
«LastName»	«FirstName»		

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Birthdate (MM/DD/YY)	Gender
			«DOB»	☐ Male ☐ Female

Practice communication preference for Appts, Rx Notices, Test Results:	Marital Status	Social Security Number
☐ Phone ☐ Text (SMS) ☐ Both	☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Employer Name	Occupation/Job Title	☐ Full-time ☐ Part-time

Employer Address	City	State	Zip Code

Guarantor Information

Last Name	First Name	M	Relationship to Patient

Address	City	State	Zip Code

Home Phone	Cell Phone	Birthdate (MM/DD/YYYY)	Social Security Number

Emergency Contact

Relationship to Patient	Last Name	First Name	M
☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Care Giver ☐ Other_____			

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Primary Insurance Information

Primary Insurance Company	Policy ID Number #

Coverage Start Date (MM/DD/YY)	Subscriber/Insured Name	Patient Relationship to Insured
		☐ Spouse ☐ Parent ☐ Child ☐ Care Giver ☐ Sibling ☐ Other_____

Group Number #	Group Name

Secondary Insurance Information

Secondary Insurance Company	Policy ID Number #

Coverage Start Date (MM/DD/YY)	Subscriber/Insured Name	Patient Relationship to Insured
		☐ Spouse ☐ Parent ☐ Child ☐ Care Giver ☐ Sibling ☐ Other_____

Group Number #	Group Name

St. Joseph's/Candler | Physician Network

Patient Registration continued

Rx History Consent and Advance Directive

Indicate whether you consent for your provider to view your Rx history from external sources.

❑ Yes ❑ No

Advance Directive protects your right to refuse medical treatment that you do not want or to request treatment you do want.

Do you have an Advance Directive? ❑ Yes ❑ No

If NO, would you like more information? ❑ Yes ❑ No

Patient Portal Information

Enable Web Portal? ❑ Yes ❑ No

Email Address Required:

Additional Information

Race

❑ Asian ❑ Black ❑ Hispanic ❑ White

❑ Other_____

Ethnicity

❑ Hispanic or Latino

❑ Non-Hispanic or Non-Latino

Language

❑ English ❑ Spanish

❑ Sign Lang ❑ Other _____

If the preferred facility is not designated by the Patient, all tests will be sent to St. Joseph's/Candler facilities and the Patient will be responsible for payment.

Laboratory

❑ St. Joseph's/Candler ❑ LabCorp ❑ Quest Diagnostics

❑ Other_____

Radiology / X-ray

❑ St. Joseph's/Candler

❑ Other_____

Pharmacy Information

Pharmacy Name (Primary)	Phone	Fax

Address	City	State	Zip Code

Authorization to Treat & Assignments of Benefits

I do hereby consent to and Authorize the performance of all treatments, surgeries and medical services deemed advisable by the health care providers and staff of SJ/C Physician Network to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I request that payment of authorized benefits be made to SJ/C Physician Network and authorize SJ/C Physician Network to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

❑ YES ❑ NO Initial _____

I have read and understand the above statements and agree to be bound by its terms and conditions. I understand that I may be selected to participate in a brief survey about my visit and choose to receive communications from SJ/C Physician Network by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment.

_____ _____

Patient Signature **Date**

_____ _____

Patient's Guardian or Capacity *Date*

_____

Relationship to Patient

St. Joseph's/Candler | Physician Network

Patient Medical History

Today's Date: _____

Last Name: _«LastName»_____ First Name: __«FirstName»__ _____ Middle: _____

Chief Complaint

What is the main reason for your visit today? (Describe your problem in detail) _____

_____

_____

History of Present Illness

Location of the problem: _____ How long does the problem last: _____

When did you first notice the problem? _____

Is the problem constant or variable? ❑ Dull then sharp ❑ Very sharp then stops ❑ Constant

Is anything else occurring at the same time? ❑ Yes ❑ No If yes, please explain: _____

_____

On a scale of 0 – 10, with 0 being the least painful and 10 being the most painful. Circle the number of your pain below:

Less pain 0 1 2 3 4 5 6 7 8 9 10 **More pain**

Past Medical History

❑ Arthritis	❑ Gall Bladder Disease	❑ Liver Problems	❑ Tuberculosis
❑ Asthma	❑ Heart Disease/Heart Attack	❑ Thyroid Disease	❑ Reflux/Heart Burn
❑ Bleeding Disorder	❑ Stroke/Mini-stroke	❑ Lung Problems	❑ Kidney Problems
❑ Seizure Disorder	❑ High Blood Pressure	❑ Migraines	❑ Irregular Heart Beat
❑ Neck/Back Problem	❑ Diabetes	❑ Cancer: Organ _____	

Past Procedure History

	Date (Year)		Date (Year)
❑ Heart Bypass/Valve Replacement	_____	❑ Stomach Surgery	_____
❑ Hernia Repair	_____	❑ Appendix Removal	_____
❑ Gallbladder Removed	_____	❑ Back/Neck Surgery	_____
❑ Joint Replacement	_____	❑ Tonsils Removal	_____
❑ Bladder/Kidney Surgery	_____	❑ Organ Transplant	_____

St. Joseph's/Candler | Physician Network

Patient Family and Social History

	Alive, Deceased, Unknown	Age	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown	Other
Father										
Mother										
Son(s)										
Daughter(s)										
Brother(s)										
Sister(s)										
Paternal Grandfather										
Paternal Grandmother										
Maternal Grandfather										
Maternal Grandmother										

How many of the following do you have?

Brothers _____ Sisters _____ Sons _____ Daughters _____

Social History

Tobacco Use

❑ CURRENT SMOKER Date started?_____ How often? ❑ Every day ❑ Some days

How many? ❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31+

How soon after you wake? ❑ Within 5min ❑ 6-30min ❑ 31-60min ❑ after 60min

Interested in quitting? ❑ Ready to quit ❑ Thinking ❑ Not ready

❑ FORMER SMOKER Date last smoked?

How long since last smoked? ❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ 1-5 years ❑ 5+ years

What type? ❑ Cigarettes ❑ Cigars ❑ Smokeless ❑ Pipe ❑ Other

❑ NEVER SMOKED

Alcohol Use

Did you have a drink in the past year? ❑Yes ❑No

How often? ❑Mthly ❑2-4 times a mth ❑2-3 times a wk ❑4 or more a wk

How many drinks on a typical day? ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ 7-9 ❑ 10+

How often you have 6 or more on occasion: ❑ Never ❑ Monthly ❑ Weekly ❑ Daily

Illicit Drug Use

Have you used drugs other than those for medical reasons in the past year? ❑ Yes ❑ No

What type? ❑ Amphetamines ❑ Cocaine ❑ Ecstasy ❑ LSD ❑ Crack ❑ Meth

❑ Prescription Opiates ❑ Heroin ❑ Marijuana ❑ Suboxone ❑ PCP

Route? ❑ Injected ❑ Intranasal ❑ Smoked

Frequency? ❑ Daily ❑ Weekly ❑ Monthly

Are you in treatment? ❑ Yes ❑ No

St. Joseph's/Candler | Physician Network

Patient Allergies and Medications

List Allergies below:

Name of Medication/Substance	What kind of reaction do you have?

Are you taking any medications? ❑ YES ❑ NO

If YES, list all current medications below you are taking and bring prescription bottles to your visit.

Medication Name	Dosage	Frequency	Reason for Medication	Prescribing Physician

ST. Joseph's/Candler | Physician Network

Patient Review of Systems

Gastrointestinal	Cardiovascular	Constitutional Symptoms
❑ Abdominal Pain	❑ Chest Pain	❑ Fever
❑ Nausea	❑ Shortness of Breath	❑ Chills
❑ Vomiting	❑ Varicose veins	❑ Sweating
❑ Diarrhea	❑ Palpitations	❑ Weight loss
❑ Constipation	❑ Swelling of extremities	❑ Weakness
❑ Heartburn	❑ Other _____	❑ Other _____
❑ Burping		
❑ Blood in stool		
❑ Other_____		

Skin	Eyes	Musculoskeletal
❑ Skin rash	❑ Blurred Vision	❑ Joint pain
❑ Boils	❑ Double Vision	❑ Back pain
❑ Persistent itch	❑ Other _____	❑ Neck pain
❑ Change in fingernails		❑ Other _____
❑ Hair loss		
❑ Other _____		

Ear / Nose / Throat	Hematologic / Lymphatic	Neurological
❑ Ear pain	❑ Swollen glands	❑ Tremors
❑ Hard of hearing	❑ Easy bruising	❑ Dizzy spells
❑ Sore throat	❑ Other _____	❑ Memory Problems
❑ Runny nose		❑ Frequent Headaches
❑ Other _____		❑ Other _____

Respiratory	Endocrine	Allergic / Immunologic
❑ Wheezing	❑ Excessive thirst	❑ Seasonal allergies
❑ Frequent cough	❑ Fatigue	❑ Sneezing
❑ Sputum	❑ Other _____	❑ Watery/Itchy Eyes
❑ Other _____		❑ Other _____

Female Genitourinary		Male Genitourinary
❑ Frequent urination		❑ Pain in the testicles
❑ Urgent urination		❑ Penile discharge
❑ Pain on urination		❑ Blood in urine
❑ Vaginal discharge		❑ Night time urination
❑ Urine leakage		❑ Frequent urination
❑ Lower abdominal pain		❑ Dribbling of urine
❑ Blood in urine		❑ Difficulty starting urine
❑ Painful menstruation		❑ Other _____
❑ Other _____		

St. Joseph's/Candler | Physician Network

Authorization for Release of Information
Purposes of HIPAA Disclosure

I hereby authorize SJ/C Physician Network to release the following information from the health records of:

Patient Name: **«FirstName» «LastName»** DOB: : **«DOB»** SSN: : «SSN»

TO BE RELEASED TO:

First and Last Name	Relationship	Date of Birth	Phone Number

INFORMATION TO BE RELEASED:

- ❑ Entire Record
- ❑ Lab Results
- ❑ Nursing Notes
- ❑ Demographics
- ❑ Emergency Room Notes
- ❑ Radiological Results
- ❑ Physician Orders
- ❑ Medication Records

FOR THE PURPOSE OF:

- ❑ Anything on behalf of the patient
- ❑ Creating/Changing/Canceling appointments
- ❑ View or correct demographic information to include signing in on my behalf
- ❑ Receive documents containing my PHI (Protected Health Information) on my behalf with an authorization for release of information signed by me.
- ❑ Picking up prescriptions/forms and or medications on my behalf.
- ❑ Speaking to SJ/C Physician Network staff regarding my PHI including but not limited to billing and insurance information on my behalf.
- ❑ Other: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Physician Network or in a manner described in the Notice of Privacy Rights. I also understand that if the information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above. I understand that this Release of Information will expire within **ONE YEAR** from the date listed below.

_____ _____

Patient Signature **Date**

_____ _____

Patient's Guardian or Capacity *Date*

_____

Relationship to Patient

St. Joseph's/Candler | Physician Network

Office and Financial Policies

Appointments

We believe that our patient's time is valuable and every effort is made to keep your waiting time to a minimum. If you are unable to keep your appointment, please notify the office as soon as possible. This courtesy allows us to give appointments to another patient. If you do not cancel your appointment 24 hours prior to the scheduled appointment time a No Show fee will be charged to your account. If you have 3 or more No Shows within a 12 month period you could be discharged from the practice.

Financial Policy

- Your Insurance Card(s) and Driver's License (Picture ID) will need to be presented each time you visit our practice to assure we have the most recent information. If insurance card is not provided, appointment will be handled as self-pay and payment for services will be collected prior to being seen.
- Co-payments must be paid prior to seeing the health care provider on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you we file your insurance claims, therefore it is your responsibility to provide our office with up to date billing information.
- Please understand that your insurance is a contract between you and your insurance company and you are ultimately responsible for the bill. If you have not received an explanation of benefits within 30 days of seeing your health care provider you are expected to contact your insurance company for an explanation as to why payment has been delayed.
- Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.
- It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reason for non- payment will be assessed a $30.00 NSF fee for which the patient will be held responsible.
- Patients with no financial ability to pay St. Joseph's/Candler charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance. Please notify the Front Desk staff if you would like more information about how to apply for financial assistance.

Patient Portal

The patient portal allows patients to manage their personal health information at their own convenience. You will be able to securely and confidentially exchange non-emergent messages with our practice, request prescription refills, request and keep track of appointments, view referrals to specialists, view lab and imaging results and update your contact information.

Prescription Refills

You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy up to 48 hours to process your refill request. Please note that prescriptions will not be refilled after hours, on weekends or holidays. Some prescriptions cannot be refilled if you have not seen your health care provider within the last 3-6 months. If you have mail away prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail away prescriptions to allow adequate time for paperwork to be processed.

Test Results

Laboratory tests can be performed in our in-house lab, but some special tests may be sent out. You must have an appointment for lab tests and a lab order from your provider. Your health care provider will review your lab/imaging results and notify you via voice message letter or electronically sent to your patient portal. If you have not heard from us within 7 days, please call our office.

Referrals and Prior Authorizations

Most insurance plans require a patient to be seen by their primary care provider prior to seeing a specialist. If your insurance plan requires a prior authorization you must verify your insurance has approved the visit before seeing the specialist. Otherwise, you will be responsible for any incurred charges.

Medical Records

Please note that requests for any health information cannot be processed without a signed medical record release from the patient or legal representative. This service is outsourced and processed weekly. Please allow up to 7 business days for your request to be processed. A fee may be charged for this service.

Patient Signature _____ **Date** _____

Patient's Guardian or Capacity _____ *Date* _____

St. Joseph's/Candler | Physician Network

Notice of Privacy Practices

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.

The following organizations use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive through healthcare operations. The information described in this Notice of Privacy Rights includes your medical records.

The Organizations who are covered under this Notice include St. Joseph's Hospital, Candler Hospital, each Hospital's Medical Staff, the Hospital Based Physician Practices providing services in Anesthesiology, Radiology, Pathology and the Emergency Rooms and Hospitalists. (Collectively "We")

How We May Use or Disclose Your Health Information

For Treatment. We may use your health information to provide you with medical treatment or services. For example, information obtained by a healthcare provider, such as a physician, nurse, or other person providing health services to you, will be recorded in your record that is related to your treatment. This information is necessary for healthcare providers to determine what treatment you should receive. Healthcare providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel and others to: evaluate the performance of our staff; assess the quality of care and outcomes in your cases and similar cases; learn how to improve our facilities and services; and determine how to continually improve the quality and effectiveness of the healthcare we provide. This includes sending information to a third-party to conduct research on patient satisfaction and effectiveness of the services performed.

Customer Services. We may use your information to forward your mail received here in the hospital after you have left the facility.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Fund Raising. We may use certain information (name, address, telephone number, dates of service, age, insurance status and gender) to contact you in the future regarding charitable support or communications about St. Joseph's/Candler or its affiliates. All charitable support will be used to improve the healthcare services, expand patient programs and purchase state-of-the-art technology for St. Joseph's/Candler.

Required by law. We may use and disclose information about you as required by law. For example, St. Joseph's Hospital or Candler Hospital may disclose information for the following purposes: for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Funeral Directors/Coroners. Health information may be disclosed to funeral directors or coroners to enable them to carry out
their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for organ, eye or tissue donation purposes. This includes disclosures to an appropriate tissue bank or organ donation organization.

Research. We may use your health information for research purposes as allowed by law. The Institutional Review Board will review the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety. Your health information may be disclosed if there is a potential serious threat to the health or safety of you or any other person as allowed by law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches

of the named services.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent St. Joseph's Hospital or Candler Hospital has taken action in reliance on such.

Your Rights to Privacy:

Your Rights to Privacy include:

- You have the right to request a restriction on certain uses and disclosures or your information. However, the organizations listed above are not required to agree to a requested restriction.
- You have the right to obtain a paper copy of the Notice of Privacy Practices upon request to the Privacy Official or a member of the organization.
- You have the right to inspect and obtain a copy of your health record as allowed by state and federal regulations.
- You may also request an amendment to your health record as allowed by state and federal regulations.
- You may also request communications of your health information by alternative means or at alternative locations. For example, by sending information to a P.O. Box instead of your home address.
- You may revoke your Authorization to use or disclose health information except to the extent that action has already been taken by providing written notice to the Health Information Management Department at St. Joseph's/Candler Health System, Inc., 5353 Reynolds Street, Savannah, Georgia 31405.
- You may also receive an accounting of disclosures made of your health information as provided by federal regulations by sending a written request to the Health Information Management Department at the address listed above.

If you have a concern or complaint about your privacy rights, you may direct the concern or complaint in writing to:

St. Joseph's/Candler
Privacy Official
5353 Reynolds Street
Savannah, Georgia 31405

You may also contact the Department of Health and Human Services, if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Our Obligations Under This Joint Notice.

We are required by law to maintain the privacy of protected health information and to provide you with a Notice of our legal duties and privacy practices with respect to the protected health information. We will accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations. For reasons other than those stated above or as allowed by law, we will obtain your written authorization to use or disclose your health information. We will notify you if we are unable to agree to a requested restriction on how your information is used or disclosed. We are also required to comply with the terms of the Notice currently in effect.

We reserve the right to change our information practices and to make the new provisions effective for all protected health information we maintain. The revised Notice will be made available to you by requesting a copy of an updated Notice. You may send a written request to the Privacy Official for St. Joseph's / Candler Health System, Inc. at 5353 Reynolds Street, Savannah, Georgia 31405.

You many also view this notice on our website, www.sjchs.org

This Notice of Privacy Rights is effective as of April 14, 2003. Revised: 2016

_____

Patient Signature

_____

Date

_____

Patient's Guardian or Capacity

_____

Date

St. Joseph's/Candler | Physician Network

Authorization for Release of Information

«PrimaryServiceLocation»
«RendPrMailingAddr1»,«RendPrMailingAddr2»
P: «RendPrPhone» F: «RendPrFax»

I hereby authorize «PrimaryServiceLocation» to release OR receive the following information from the health records of:

Patient Name: **«FirstName» «LastName»** DOB: : **«DOB»** SSN: : «SSN»

OBTAIN FROM	RELEASE TO
Name of Entity or Physician	Name of Entity or Physician
Address	Address
City, State, Zip	City, State, Zip
Phone and/or Fax Number	Phone and/or Fax Number

Information to be released:

- ❑ Entire Record
- ❑ Lab Results
- ❑ Nursing Notes
- ❑ Demographics
- ❑ Emergency Room Notes
- ❑ Radiological Results
- ❑ Physician Orders
- ❑ Medication Admin Record

For dates of services rendered _____ through _____

For the purpose of: _____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Medical Group at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or dependency, psychiatric or psychological illness, mental illness or retardation and acquired immune deficiency (aids) syndrome.

The Entity listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be redisclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **NINETY (90) days** from the date listed below.

Patient Signature _____ **Date** _____

Patient's Guardian or Capacity _____ *Date* _____

Relationship to Patient _____

For Health Information Management Department Use Only:

Request taken by: _____ Date completed: _____

Method of Release: _____ Mail _____ Pick Up _____ Fax