Authorization to Receive and Disclose Patient Information

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Email: healthinfo@schneckmed.org

Patient Information (please print):

First Name:	Middle Initial:	Last Name:	
Address:	City:	State:	Zip:
Date of Birth (MM/DD/YY)	Phone:		

Who are you authorizing to receive or disclose your records?

Organization Name: _____ Fax #: _____
Address: _____

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____/____/____ through ____/____/____

- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ Billing Records
- ☐ Progress Notes
- ☐ Operative/Procedure Reports
- ☐ Test Results (X-ray, lab/pathology results) Please Specify:_____
- ☐ Other—Please Specify:_____

Special authorization: State and Federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained.

- ☐ HIV testing and results
- ☐ Psychotherapy notes
- ☐ Alcohol, drug or substance abuse records
- ☐ Mental Health Records
- ☐ Genetic records

Purpose of release:

- ☐ Continuing care
- ☐ Transfer of care
- ☐ Social Security Appeal
- ☐ Insurance Application*
- ☐ Insurance payment/claim
- ☐ Litigation/legal*
- ☐ Social Security Disability Determination*
- ☐ Other: _____

*Fees may be charged in accordance with the IN Statute 760 IAC 1-71-3 and Federal Rule 45 C.F.R. § 164.524

Your Rights with respect to this authorization:

I understand I have the right to withdraw this authorization at any time. I understand that if I withdrawal this authorization I must do so in writing and present my written withdrawal to the Health Information Services department of the entity listed above. I understand that the withdrawal will not apply to information that has already been released in response to this authorization. I understand that the withdrawal will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy and will not apply to action taken in reliance upon this authorization. I understand that I will be provided a copy of the signed authorization upon request. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

This authorization will expire 60 days from the date signed unless otherwise specified _____

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Signature of Witness

Patient is:
- ☐ Minor
- ☐ Incompetent
- ☐ Deceased

Legal Authority:
- ☐ Parent
- ☐ Legal Guardian
- ☐ Executor of Estate
- ☐ POA for healthcare
- ☐ Authorized legal representative

DATE_____

PATIENT INFORMATION SHEET

Patient Name:			**Date of Birth:**	Marital Status:
Address:			Sex:	Soc. Sec.#:
City:	St:	Zip:	Do we have your permission to leave information related, but not limited, to appointment, billing, negative test results on answering machine/ voicemail at? ***(please check box)***: ☐ Home ☐ Cell ☐ Work ☐ No	
Home Ph.#:		Cell Ph.#:	Work Ph. #:	Place of Employment:
Email Address:			Worker's Comp? ☐ Yes ☐ No	Date of Injury: _____

RACE: ***(Please Check appropriate boxes)***

☐ CAUCASIAN ☐ ASIAN ☐ AFRICAN AMERICAN ☐ NATIVE HAWAIIAN ☐ OTHER PACIFIC ISLANDER

☐ AMERICAN INDIAN / ALASKA NATIVE ☐ MORE THAN ONE RACE ☐ REFUSED TO REPORT

Primary Language:

Ethnicity(*please check box)*)

☐ HISPANIC/LATIN AMERICAN ☐ REFUSED TO REPORT ☐ NON-HISPANIC/LATIN

Responsible Party (if other than patient):		Sex:	Date of Birth:
Address:	City:	St:	Zip:
Soc. Sec.#:	Home Ph.#:	Cell Ph. #:	Work Ph.#:

Emergency Contact Name: (Outside the household) **:**

Home Ph.#:	Cell Ph.#:	Relationship:

***Insurance cards, photo ID and co-payments must be presented at time of service.**	***Insurance cards, photo ID and co-payments must be presented at time of service.**
INSURANCE NAME	**INSURANCE NAME**
SUBSCRIBER NAME	**SUBSCRIBER NAME**
ID NUMBER	**ID NUMBER**
DOB SS#	**DOB SS#**

Medical History

Patient Name: _____ DOB: _____

Medications (or provide list):

_____

_____

_____

_____

Do you use oxygen: _____ If so, how much and when: _____
Do you use a Cpap or Bipap: _____

If so, what company do you use for supplies _____

List Allergies & Reactions (rash, itching, etc.): _____

_____

Please list any other physicians you see routinely and their specialty:

_____

_____

_____

_____

_____

Are you under any pain management contracts or do you see a pain specialist?_____
If so, please list their office name and phone number:_____

_____

Past Medical History (Please X if you have these or have a history of a certain condition.)

Endocrine: ☐ Diabetes ☐ Hypothyroidism

Respiratory: ☐ Asthma ☐ COPD ☐ Sleep Apnea ☐ Shortness of Breath

Cardiovascular: ☐ Atrial Fibrillation ☐ Coronary Artery Disease ☐ Heart Failure
☐ Hypertension ☐ Myocardial Infarction ☐ Chest Pain

Gastro: ☐ GERD ☐ Peptic Ulcer Disease

Genitourinary: ☐ Kidney Stones ☐ Males: Benign Prostate Hyperplasia

Musculoskeletal: ☐ Fibromyalgia ☐ Rheumatoid Arthritis ☐ Arthritis ☐ Osteoporosis

Oncology: ☐ Anemia ☐ Blood ☐ Brain ☐ Breast ☐ Colorectal
☐ Endocrine ☐ GI ☐ Leukemia ☐ Liver ☐ Lung ☐ Lymphoma
☐ Prostate ☐ Skin ☐ Stomach ☐ Thyroid ☐ Other _____

Neurologic: ☐ Dementia ☐ Multiple Sclerosis ☐ Parkinson Disease ☐ Restless Leg Syndrome
☐ Seizures ☐ Strokes ☐ Aneurysm ☐ Migraines ☐ Sciatica

Psychiatric: ☐ Anxiety ☐ Bipolar Disorder ☐ Depression ☐ Drug Abuse ☐ Suicidal Ideation

Tobacco Use: ☐ Non-smoker ☐ Smoker: ____ Packs per Day

Alcohol Use: ☐ None ☐ 0 – 2 per Day ☐ 2+ per Day

Substance Use: ☐ None ☐ Amphetamines ☐ Tranquilizers/Sedatives ☐ Opiates
☐ Painkillers ☐ Injection Drugs ☐ Other _____

Past Surgical History

Endocrine: ☐ Parathyroidectomy ☐ Thyroid Surgery ☐ Other _____

Cardiovascular: ☐ Angioplasty ☐ Coronary Stent ☐ Heart Transplant
☐ Pacemaker ☐ Valve Replacement ☐ Other _____

Gastrointestinal: ☐ Appendectomy ☐ Colectomy ☐ Gastric Bypass ☐ Hernia Repair

Musculoskeletal: ☐ Knee Replacement (R or L | Year _____) ☐ Hip Replacement (R or L | Year _____)
☐ AKS (R or L | Year _____) ☐ Spinal Surgery ☐ Other _____

OTHER_____
_____