

Welcome

to our office

Where did you hear about us?

□ Yellow Pages (YP) □ Newspaper (NP) □ Website (WS) □ Friend or Family (FF) □ Physician Referral (PR) Other (OT)

OFFICE USE ONLY

Physician: Approved by:_____

Date:

NEW PATIENT INFORMATION (Complete if different from billing party)

Name					
Address	First	Mido	lle		Last
	State		Zip	Phone # ()	
	Sex M or F Race				
	E				
	YN By E-Mail YN				
Guarantor/Responsible Party					
Name	First				
A dalama a		Mido			Last
				Dhana	μ
					#
			: #		
	t relative not living with you				
	t relative not living with you City				
	nother physician's care, please		2ip	_ F11011e #	
	ci			Zin	
	CiCiCi				
NSURANCE					
	oany Name				
	P				
Subscriber Name	Subscriber Bi	-		ocial Security #	
	dress				
	I Insurance Name				
	P				
Subscriber Name		· · · · · · · · · · · · · · · · · · ·			

Please note whomever brings a child in to be seen is responsible for payment at time of service unless prior arrangements have been made. It is the custodial parent's responsibility to arrange reimbursement from a non-custodial parent. By signing below I hereby give my consent for Holston Medical Group to treat my minor child, under 18 years of age

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I understand that I am financially responsible for any medical service at time of service. I authorize my insurance carrier to pay to Holston Medical Group any assigned claims filed by them and authorization for release of medical information requested by my insurance company. For Medicare beneficiaries: I request payment of authorized Medigap benefits be made to me or on my behalf to Holston Medical Group and medical information about me to be released to my Medigap insurer.



PEDIATRIC HISTORY FORM

	HOLSTON MEDICAL GROUP				Chart #
Today's Date					Doctor
Mother's Name Age Occupation Father's Name Age Occupation Mark appropriate box for parents: Occupation Mark appropriate box for parents: Single Diversed Widowed Separated Child lives with:	Patient Name			Male Female	Birth Date
Mother's Name Age Occupation Father's Name Age Occupation Mark appropriate box for parents: Occupation Mark appropriate box for parents: Baread Destination Marked Directly Single Separated Destination Child lives with: Wickowed Separated Destination How many children has the mother had: Tyes, what? Yes No How many children has the mother had: Tyes, what? Yes No Uning the mother's pregnency with this child, did she: (Circle yees or no) Mark an X in appropriate box) 2. Have sag or no) Altergies Diabates Hypertension 3. Have a Kidney or biadder infection? Yes <no< td=""> No Anemia Heart Disease A Have German Measles (Rubbila)? Yes No Anemia Heart Disease Muscular Dystrophy 6. Consume Alcohd? Yes, No Martination Hournatic Frover Muscular Dystrophy 11 Yes, what? Yes No Astma Ear / Eye Disease Muscular Dystrophy 11 Was this thild premature Yes No Astma Muscular Dystrophy 11 Yes</no<>	Today's Date				
Father's Name		qe		Occupation	
Mark appropriate box for parents: Mark appropriate box for parents: MarriedSingleSeparated DivorcedVidew dSeparated DivorcedVidew dSeparated DivorcedVidew dSeparated Child lives with the mother had: How many children has the mother had: Much any brick humber is this one: Circle yeas or no) 1. Have high blood pressure? Yes No I. Have high blood pressure? Yes No 2. Have sugar nyour une? Yes No 3. Have a Kidney or bladder infection? Yes No 4. Have Gemen Measles (Rubella]? Yes No 5. Take medicines prescribed by her doctor or over the counter? Mental Retardation Counter? Yes No 6. Consume Alcohol? If yes, amountYes No No 7. Have a dependency on drugs? Yes No 8. Have a dependency on drugs? Yes No 9. Was this child bremature Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Breast med Highore Marce No Have Sizer Res Yes No </td <td></td> <td></td> <td></td> <td></td> <td></td>					
Decreted Single		go <u> </u>			
Married Single	Mark appropriate box for parents:			FAMILY HISTORY	
Divorced Widowed Separated Child lives with :: Number of people in Household:					her have any chronic illnesses?
Child lives with:					
Number of people in Household:				If Yes, what?	ildren have any chronic illnesses?
Which number is this one:	Number of people in Household:			Be any or your other on	•
Have any or your child's family (include statings, patents, uncle or aunts) had any of the following linesse disorders: BIRTH HISTORY During the mother's pregnancy with this child, did she: (Circle yes or no) 1. Have high blood pressure? Yes No 2. Have sugar in your urine? Yes No 3. Have a Kidney or bladder infection? Yes No 4. Have German Measles (Rubella)? Yes No 5. Take medicines prescribed by her doctor or over the counter? Yes No 6. Consume Alcohol? If yes, amount Yes No Birth Defects 1. Usa ship kind upoint Muscular Dystrophy 1. Was this child premature: Yes No 1. Was the birth: Normal Vaginal Breech Cesarean 10. Did you have a difficult delivery? Yes No 14. Did the child have any of the following while in the nursery: Yes No 14. Did the child have any of the following while in the nursery: Breat hing (ficility	How many children has the mother had:			If yes, what?	
BIRTH HISTORY (Mark an X in appropriate box) BIRTH HISTORY (Mark an X in appropriate box) During the mother's pregnancy with this child, did she: (Mark an X in appropriate box) (Circle yes or no) 1. 1. Have high blood pressure? Yes No 2. Have sugar in your urine? Yes No 3. Have a Kiney or bladder infection? Yes No 4. Have German Measles (Rubella)? Yes No 5. Take medicines prescribed by her doctor or over the counter? Yes No f yes, what? Goon 6. Consume Alcohol? Hyes, amount Yes No 7. Use any tobacco products? Hyes, amount Yes No 8. Have a dependency on drugs? Yes No Asthma Rheumatic Fever 10. Did you have a difficult delivery? Yes No Normal Vaginal Breact Muscular Dystrophy 11. Was the birth: Normal Vaginal Breact Muscular Dystrophy 12. Childs weight at birth Does your child have any of the following while in the nursery: Breast field have any of the following while in the nursery: Breast field Bottle fed MMUNIZATION DATES - or present copy of record DPT OPV/IVP MRR	Which number is this one:			Have any of your child's	s family (include siblings, parents
BITH HISTORY (Mark an X in appropriate box) During the mother's pregnancy with this child, did she: (Circle yes or no) (Mark an X in appropriate box) 1. Have high blood pressure? Yes 2. Have sugar in your urine? Yes 3. Have a Kidney or bladder infection? Yes 4. Have Gram Measies (Rubella)? Yes 5. Take medicines prescribed by her doctor or over the counter? Yes 11 If yes, what? Lung 6. Consume Alcohol? If yes, amount Yes No 8. Have a dependency on drugs? Yes 9. Was this child premature: Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Normal Vaginal BreechCesarean					
During the mother's pregnancy with this child, did she: (Circle yes or no) 1. Have high blood pressure? Yes No 2. Have sugar in your urine? Yes No 3. Have a Kidney or bladder infection? Yes No 4. Have German Measles (Rubella)? Yes No 5. Take medicines prescribed by her doctor or over the counter? Yes No 1f yes, what? Yes No 6. Consume Alcohol? If yes, amount Yes No 7. Use any tobacco products? If yes, amount Yes No 8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Normal Vaginal Breech Cesarean 12. Child's weight at birth Yes No 13. Was there an RH problem? Yes No 14. Did the child have any of the following while in the nursery: Breathing difficulty Breast fied				disorders:	
Circle yes or no) Allergies Diabetes 1. Have high blood pressure? Yes No 2. Have sign in your urine? Yes No 3. Have a Kidney or bladder infection? Yes No 4. Have German Measles (Rubella)? Yes No 5. Take medicines prescribed by her doctor or over the counter? Yes No Consume Alcohd? If yes, amount Yes No 7. Use any tobacco products? If yes, amount Yes No 8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Nomal Vaginal Breact Chronic Bronchitis 12. Child's weight at birth Breathing difficulty Yes No 13. Was there an RH problem? Yes No 14. Did the child have any of the following while in the nursery: Breathing difficulty Yes No 12. Child's weight at birth Bottle fed Molta Mallergies Influence 13. Was there an RH problem? Yes No If yes, what				(Mar	rk an X in appropriate box)
1. Have high blood pressure? Yes No 2. Have sugar in your urine? Yes No 3. Have a kidney or bladder infection? Yes No 4. Have German Measles (Rubella)? Yes No 5. Take medicines prescribed by her doctor or over the counter? Yes No 6. Consume Alcohol? If yes, amount Yes No 7. Use any tobacco products? If yes, amount Yes No 8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No If yes, number of weeks at birth Lung Cerobral Palsy 10. Did you have a difficult delivery? Yes No 11. Was the birth: Normal Vaginal Breast Unexpected death of a child 12. Child's weight at birth Cesarean Does your child have any known allergies to medicines, food o pollen? Yes 13. Was there an RH problem? Yes No If yes, what Moutal Zation DATES – or present copy of record per develop your child's eating habits as Seizures Yes No MR Mare TB Skin test Moud you describe your child's eating habits as Excel					
2. Have sugar in your urine? Yes No 3. Have a Kidney or bladder infection? Yes No 4. Have German Measles (Rubella)? Yes No 5. Take medicines prescribed by her doctor or over the counter? Yes No Consume Alcohol? If yes, amount Yes No 7. Use any tobacco products? If yes, amount Yes No 8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No 11. Was the bith: Normal Vaginal Breast in difficult delivery? Yes No 12. Child's weight at birth_ Yes No If yes, what Does your child have any known allergies to medicines, food o pollen? Yes No 12. Child's weight at birth_ Yes No If yes, what				Allergies	Diabetes
3. Have a Kidney or bladder infection? Yes No 4. Have German Measles (Rubella)? Yes No 5. Take medicines prescribed by her doctor or over the counter? Yes No 6. Consume Alcohol? If yes, amount Yes No 7. Use any tobacco products? If yes, amount Yes No 8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No 10. Did you have a difficult delivery? Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Breech Cesarean Does your child have any known allergies to medicines, food o pollen? 12. Child's weight at birth Yes No Immunotifient to the following while in the nursery: Breast fed Breast Immunotifient to the set of the following while in the nursery: Immunotifient to the set of the following while in the nursery: Breast fed Bottle fed MR MR Moreal Classe Yes No Jaundice Yes No Low blood sugar Yes No Seizures Yes No Breast	- .			Birth Defects	Hypertension
4. Have German Measles (Rubella)? Yes No Attnins Indredy Disease 5. Take medicines prescribed by her doctor or over the counter? Yes No Breast Mental Retardation 1. Yes, what?				Anemia	Heart Disease
4. Have German Measures (Rudenia)? Fes No 5. Take medicines prescribed by her doctor or over the counter? Yes No 6. Consume Alcoho? If yes, amount Yes Yes No 7. Use any tobacco products? If yes, amount Yes Yes No 8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No 16 yes, number of weeks at birth Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Nomal Vaginal Breech Cesarean Does your child have any known allergies to medicines, food or pollen? Yes No 13. Was there an RH problem? Yes No If yes, what Mextal Etar/ Ety Disease Indextores, food or pollen? Yes No 14. Did the child have any of the following while in the nursery: Breathing difficulty Yes No Jaundice Yes No If yes, what Immunization for pollen? Yes No Deet Historey Yes No Immunization for pollen? Yes No Jaundice Yes No Yes No Immuni				Arthritis	Kidney Disease
Breast Muscular Dystrophy Counter? Yes No If yes, what? Yes No Consume Alcohol? If yes, amount Yes No Nase adpendency on drugs? Yes No Asthma Rheumatic Fever S. Have a dependency on drugs? Yes No Asthma Rheumatic Fever 10. Did you have a difficult delivery? Yes No Emphysema Unexpected death of a child 11. Was the birth: Normal Vaginal Breast Unexpected death of a child Child 12. Child's weight at birth Breasting difficulty Yes No If yes, what Does your child have any known allergies to medicines, food or pollen? Yes No 13. Was there an RH problem? Yes No If yes, what MMUNIZATION DATES – or present copy of record Dot wo blood sugar Yes No MMR MRE Low blood sugar Yes No MMR List any medicines which your child takes: Breast fed Bottle fed MRE List any medicines which your child takes: List any medicines which your child takes: Breast fed Bottle		Yes	No	Cancer	
If yes, what?		Vee	Na		
6. Consume Alcohol? If yes, amountYes No 7. Use any tobacco products? If yes, amountYes No 8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No 16. Did you have a difficult delivery? Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Normal VaginalBreechCesarean 12. Child's weight at birth Does your child have any known allergies to medicines, food of pollen? 13. Was there an RH problem? Yes No 14. Did the child have any of the following while in the nursery: Does your child have any known allergies to medicines, food of pollen? 15. Conside the child have any of the following while in the nursery: If yes, what		res	INO		
7. Use any tobacco products? If yes, amount Yes No Astma Rheumatic Fever 8. Have a dependency on drugs? Yes No Astma Rheumatic Fever 9. Was this child premature: Yes No If yes, number of weeks at birth Tuberculosis 10. Did you have a difficult delivery? Yes No Ear / Eye Disease Unexpected death of a child 10. Was the birth: Normal Vaginal Breech Cesarean Does your child have any known allergies to medicines, food of pollen? Yes No 12. Child's weight at birth Yes No Does your child have any known allergies to medicines, food of pollen? Yes No 13. Was there an RH problem? Yes No If yes, what	· · · · · · · · · · · · · · · · · · ·	Voc	No	-	·
8. Have a dependency on drugs? Yes No 9. Was this child premature: Yes No 10. Did you have a difficult delivery? Yes No 11. Was the birth: Nomal Vaginal Breech Cesarean 12. Child's weight at birth Seizures Yes No 13. Was there an RH problem? Yes No 14. Did the child have any of the following while in the nursery: Yes No Jaundice Yes No Low blood sugar Yes No Seizures Yes No DIET HISTORY Has this child been: Breast fed Breast fed Bottle fed MMR Has this child been: Excelent List any medicines which your child takes: Fair Poor Has your child been hospitalized for any operations or medical	-				
9. Was this child premature: Yes No If yes, number of weeks at birth					
If yes, number of weeks at birth 10. Did you have a difficult delivery? Yes No 11. Was the birth: Normal Vaginal Breech Cesarean 12. Child's weight at birth 13. Was there an RH problem? 14. Did the child have any of the following while in the nursery: Breathing difficulty Jaundice Low blood sugar Seizures Ves No IMMUNIZATION DATES - or present copy of record DPT OPV/IVP DIET HISTORY Has this child been: Breast fed Bottle fed Kould you describe your child's eating habits as Excellent Good Poor Has your child been hospitalized for any operations or medical					Tuberculosis
10. Did you have a difficult delivery? Yes No 11. Was the bith:		100	110		Unexpected death of a
11. Was the bitth: Normal Vaginal Breech Cesarean 12. Child's weight at birth Does your child have any known allergies to medicines, food o pollen? 13. Was there an RH problem? Yes No 14. Did the child have any of the following while in the nursery: Breathing difficulty Jaundice Yes No Low blood sugar Yes No Seizures Yes No DIET HISTORY MMR_ Has this child been: Breast fed Breast fed Bottle fed Good Fair Poor Has your child been hospitalized for any operations or medical		Yes	No	Ear / Eye Disease	
12. Child's weight at birth					
12. Child's weight at birth	Normal Vaginal Breech Cesarean			Does your child have ar	ny known allergies to medicines, food or
13. Was there an RH problem? Yes No 14. Did the child have any of the following while in the nursery: If yes, what				pollen?	Yes No
14. Did the child have any of the following while in the nursery: Breathing difficulty Yes No Jaundice Yes No Low blood sugar Yes No Seizures Yes No DIET HISTORY MMR_ Has this child been: OPV/IVP_ Breast fed Bottle fed Good Fair Poor Has your child been hospitalized for any operations or medical	13. Was there an RH problem?	Yes	No	•	
Jaundice Yes No Low blood sugar Yes No Seizures Yes No DIET HISTORY MMR	14. Did the child have any of the following while in the nursery:	:			
Low blood sugar Yes No IMMUNIZATION DATES - or present copy of record Seizures Yes No DPT	Breathing difficulty	Yes	No		
Seizures Yes No DPT		Yes	No		
DIET HISTORY OPV/IVP	5			IMMUNIZATION DATE	S – or present copy of record
DIET HISTORY MMR Has this child been: MMR Breast fed Bottle fed Would you describe your child's eating habits as TB Skin test Excellent Good Fair Fair Poor Has your child been hospitalized for any operations or medical	Seizures	Yes	No	DPT	
Has this child been: Breast fed Bottle fed TB Skin test Would you describe your child's eating habits as List any medicines which your child takes: Excellent Good Fair Has your child been hospitalized for any operations or medical					
Has this child been: Breast fed Bottle fed TB Skin test Would you describe your child's eating habits as List any medicines which your child takes: Excellent Good Has your child been hospitalized for any operations or medical Poor Has your child been hospitalized for any operations or medical					
Breast fedBottle fed Would you describe your child's eating habits asList any medicines which your child takes: Excellent Good Fair PoorHas your child been hospitalized for any operations or medical				······ ·	
Would you describe your child's eating habits as List any medicines which your child takes: Excellent				TB Skin test	
Excellent Good Fair Poor Has your child been hospitalized for any operations or medical				List any medicinos which	th your child takes:
Good Fair Poor Has your child been hospitalized for any operations or medical					an your onniu lakes.
Fair Poor Has your child been hospitalized for any operations or medical	Good				
Poor Has your child been hospitalized for any operations or medical					
					spitalized for any operations or medical
Has your child taken Vitamins: Yes No If yes, what?	Has your child taken Vitamins:	Yes	No	If yes what?	

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1. Measles

- 2. Mumps
- 3. Chicken Pox

- 5. German Measles
- 6. Croup
- 7. Frequent bronchitis or pneumonia
- 8. Frequent ear or throat infections
- 9. Asthma
- 10. Seizures

4. Rheumatic Fever



PEDIATRIC MEDICAL HISTORY (Age 2 & Above)

Today's Date / /	Chart #				
Primary Provider					
Patient's Name	□ Male □Fema	le Birth Date//			
Mother's Name	Age	Occupation			
Father's Name	Age	Occupation			
Parents are □married □single □divorced	□separated □widowed	Number of people in household			
Child Lives with:	Does he/she attend day	care □yes □no; Days per week			
How many children has the mother had?	Which number is this C	Child?			
Has this child had any serious health problems	since the last update?				

Has this child had any immunizations by other providers since the last update? Uyes Ino_____

Family History

Please check the appropriate area	Mother	Father	Sibling	mGM	mGF	pGM	pGF	other
Allergies – Food								
Allergies – Seasonal								
Allergies – Other								
Asthma								
Anemia								
Arthritis – Rheumatoid								
Arthritis – Other								
Cancer – Childhood								
Cancer – Leukemia								
Cancer – Other								
Emphysema – Nonsmoker								
Emphysema – Smoker								
Chronic Bronchitis								
Frequent Ear Infections								
Frequent Serious Infections								
Hearing difficulty/deafness								
Childhood eye disorder								
Childhood vision problem								
Diabetes – Insulin dependent								
Diabetes – non-insulin dependent								
High Blood Pressure								
High Cholesterol								
High Triglycerides								
Kidney disease								
Epilepsy – Convulsions								
Mental retardation								
Cerebral Palsy								
Tuberculosis								
Unexpected death of a child								
Birth defect/congenital disorder								
Other								

Employee Signature



DATE RECEIVED: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have reviewed and/or received a copy of the *Notice of Privacy Practices*, which provides a more complete description of how my protected health information (PHI) may be used or disclosed. I understand that Holston Medical Group reserves the right to change their notice and information practices and that I may view a copy of the current *Notice* on Holston Medical Group's website, www.holstonmedicalgroup.com/hipaa, in any of their offices, or by a request in writing.

I also understand that Holston Medical Group participates in the OnePartner Health Information Exchange (OnePartner HIE) and may make my medical information available electronically, or may electronically transmit my medical information to a third party, in order to fulfill provider obligations to release my medical information in the future.

Print Patient Name	Patient Date of Birth
Patient Signature (if applicable)	Date
Authorized Representative Signature	Relationship to Patient

I understand that my protected health information will only be verbally communicated to those individuals listed below. Those individuals will be required to provide the last four (4) digits of my Social Security Number, along with my date-of-birth, before any information will be discussed with them.

List the individuals that you want protected health information given to:

FOR INTERNAL USE ONLY:

Reason Acknowledgement Could Not Be Obtained:





NO SHOW POLICY

Welcome to Holston Medical Group. Please take time to review the following information pertaining to our policy for no show appointments.

We understand that scheduling conflicts occur from time to time. However, we request at least two hours advance notice if you are unable to keep your scheduled appointment(s). Two or more missed appointments may result in your family being dismissed from Holston Medical Group. Patients that fail to show up for a scheduled appointment <u>may be charged a fee</u> for not providing the office with prior notice of cancellation.

Holston Medical Group physicians have developed our No Show policy in an effort to better serve our patients by providing same day appointments to those who are sick and need to be seen. If someone schedules an appointment and does not show for the visit, we have lost an available time that could have been used for a sick patient.

We look forward to providing your health care needs. Your understanding and cooperation helps us to provide available appointments for patients who urgently need them.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no show appointments.

Please Print Patient Name	Date of Birth	Account Number
Please Sign Authorized Representative	Relationship to Patient	
Witness	Date	



Parental Pre-Authorization for Minors

It is the policy of Holston Medical Group to comply with state and federal laws that govern the treatment of children under the age of 18. Under this law, it is necessary to have the presence of a parent or legal guardian or a signed document giving consent before evaluation and/or treatment can be rendered to children under the age of 18.

I (we) request and authorize Holston Medical Group and its personnel to provide medical care to my child:

Child's Name	Date of Birth	
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List any individuals other than the legal guardians to whom you give permission to bring your child in for medical treatment during your absence.

Name	_ Relationship
Name	Relationship

Note: If there is any special parental or custodial relationship (such as custody with one parent only, legal custody/guardians with no-parent, etc.) Please explain in the space below with your signature, printed name and phone number at which you may be reached. A copy of the legal document will need to be obtained.

 Legal Guardian/Parent's Signature_____

 Printed Name_____
 Phone______

 Witness______
 Date______



AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Holston Medical Group, PC is dedicated to maintaining the privacy of your protected health information (PHI), which is your individually identifiable health information (this includes such data as your name, address, phone number, date of birth, Social Security Number, account information, medical record number, or any other unique identifying number). In conducting our business, we will maintain records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand the disclosed information may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name:	DOB: SSN:			
I authorize Holston Medical Group to <i>release</i> copies of my records <i>to</i> :	I authorize Holston Medical Group to <i>obtain</i> copies of my records <i>from</i> :			
Name of Physician or Institution, etc.	Name of Physician or Institution, etc.			
Address	Address			
City, State, Zip	City, State, Zip			
Which dates of treatment do you need records for?	Which dates of treatment do you need records for?			
**Please check all that apply:	Please send requested records to:			
**Information to be Released: Office Notes (Encounter Notes, Telephone Notes, Memos) Radiology Reports				
(X-rays, CT Scans, MRI, Ultrasound,etc.) Lab Results Immunization Record Consultations/Referrals Other	**Information will be used/disclosed for the following purpose(s): Continuation of Care (for another provider) Personal Use Other			

The patient or the patient's representative must read and initial the following statements:

- 1. I understand that the information in my health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about psychiatric services, and treatment for alcohol and drug abuse.
 - 2. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
 - 3. I understand that I may revoke this authorization at any time by notifying HMG in writing. If I do revoke the authorization, it will not have any effect on any actions taken by HMG prior to their receipt of the revocation. Unless otherwise noted, I understand this authorization will expire ninety days from the date of my signature.

Signature of patient or patient's representative Printed name of patient or patient's representative			Date	
			Relationship to patient	HMG.650
*For Internal Use Only: Photo ID provided	Yes	No	If No, attach a copy of the form used to validate the signature.	