CENTRAL OHIO PRIMARY CARE

PATIENT DEMOGRAPHIC INFORMATION - ADULT

Please Complete This Entire Form. Thank You!

Today's Date: _____/_____/____ **Referred By *(If Applicable)*: _____**

PATIENT INFORMATION **OFFICE USE (P#):**

LAST NAME:	LEGAL FIRST NAME:	MIDDLE INITIAL:	DATE OF BIRTH *(mm/dd/yyyy)*:
PREFERRED NAME:	HOME PHONE: ( )	CELL PHONE: ( )	PRIOR NAME(S):

GENDER IDENTITY: □ Male □ Female □ Female-to-Male (FTM) /Transgender Male/Trans Man
□ Male-to-Female (MTF) /Transgender Female/Trans Woman □ Genderqueer or Non-Binary
□ Choose not to disclose □ Something else, please describe:

GENDER PRONOUNS: □ she/her/hers □ he/him/his □ they/them/their □ Other: _____

SEX ASSIGNED AT BIRTH: □ Male □ Female □ Unknown

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Separated

SEXUAL ORIENTATION:
□ Straight or Heterosexual □ Lesbian, Gay □ Bi-sexual □ Do not know □ Choose not to Disclose
□ Something else, please describe:

MAILING ADDRESS:	CITY:	STATE:	ZIP:
PHYSICAL ADDRESS *(If different from mailing address)*:	CITY:	STATE:	ZIP:

Preferred Pharmacy: Pharmacy Telephone: ( )

E-MAIL ADDRESS:	USE E-MAIL ADDRESS FOR PATIENT PORTAL:	SOCIAL SECURITY #:
□ None □ Prefer Not to Disclose	□ Yes □ No □ Not Applicable	

RACE: □ American Indian/Alaskan Native □ Asian □ Black/African American
□ Native Hawaiian/Other Pacific Islander □ White □ Refuse to Report □ Other

PREFERRED LANGUAGE: □ English □ Spanish
□ Other (*please specify*):
Translator Needed: □ Yes □ No

ETHNICITY: □ Hispanic/Latino
□ Non-Hispanic/Latino
□ Refuse to Report

CURRENT LEVEL OF CARE: □ Hospice
□ Permanent Nursing Facility (Long Term Care, Memory Care Unit) Facility Name:
□ Not Applicable

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	RELATIONSHIP *(Please specify)*:
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

PLEASE CONTINUE ON THE BACK SIDE OF THIS FORM

ADDITIONAL CONTACT (OPTIONAL)

LAST NAME:	FIRST NAME:	RELATIONSHIP *(Please specify)*:
HOME PHONE: ( )	CELL PHONE: ( )	MAY WE RELEASE PROTECTED HEALTH INFORMATION TO THIS INDIVIDUAL: □ Yes □ No

EMPLOYER INFORMATION

EMPLOYER NAME:	EMPLOYER PHONE NUMBER: ( )
EMPLOYMENT STATUS: □ Employed □ Full Time □ Part Time □ Retired □ Self Employed □ Unemployed □ Active Military □ Student	

INSURANCE INFORMATION

(Please present all current insurance cards to the Front Desk)

I HAVE INSURANCE: □ Yes □ No *(Self Pay)*			
PRIMARY INSURANCE:		SECONDARY INSURANCE:	
SUBSCRIBER:	RELATION:	SUBSCRIBER:	RELATION:
SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with your insurance company? □ Male □ Female		SEX/GENDER with Insurance Company COPC recognizes your gender identity. For insurance/billing purposes, what sex/gender marker is on file with your insurance company? □ Male □ Female	
DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:	DATE OF BIRTH *(mm/dd/yyyy)*:	SOCIAL SECURITY #:

CONFIDENTIAL COMMUNICATION

(I hereby request to receive confidential communications from COPC in the following manner)

TELECOMMUNICATIONS –Please leave messages regarding my protected health information as follows (*Check Preferred*):

□ Home Phone of Record □ Brief □ Extended
□ Cell Phone of Record □ Brief □ Extended
□ Work Phone of Record □ Brief □ Extended

Example of Extended: Lab Results Example of Brief: Time/Day of Appointment

POSTAL COMMUNICATIONS –Please mail my protected health information to me at (*Select One*):

□ Mailing Address of Record □ Street Address of Record
□ Other: _____

Street Address City State Zip

ADVANCE DIRECTIVES

DO YOU HAVE A LIVING WILL? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTH CARE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)
DO YOU HAVE A DO NOT RESCUSITATE? □ No □ Yes
(If yes, please provide a copy to the Front Desk)

HOW DID YOU HEAR ABOUT US?

□ Community Event □ COPC Website □ Facebook □ Instagram □ Health Plan Website □ Internet Search
□ Online Reviews □ Outdoor/ Billboard Advertisement □ Print Advertisement □ Radio Advertisement
□ Television Advertisement □ Referred by COPC Physician □ Referred from Friend/Family □ Other_____

FOR COPC SPECIALTY PATIENTS ONLY: PRIMARY CARE PROVIDER

Primary Care Provider:	PHONE NUMBER: ( )

_____ _____ _____
Patient Printed Name | Patient Signature | Date Signed

_____ _____ _____
Legal Guardian Printed Name (*if applicable*)* | Legal Guardian Signature (*if applicable*)* | Date Signed

CENTRAL OHIO℠
PRIMARY CARE

Adult Comprehensive Patient History

☐ New Patient ☐ Established Patient

Name:_____D.O.B_____ Age:_____ Date:_____

Past History: *Check all that apply*

- ☐ Acid reflux
- ☐ Alcohol or Drug problems
- ☐ Allergy problems
- ☐ Anemia
- ☐ Artery problems
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Cancer
- ☐ Colitis
- ☐ Crohn's disease
- ☐ Depression, Anxiety
- ☐ Diabetes
- ☐ Emphysema
  - ☐ Other lung disease
- ☐ Esophagitis, ulcers
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart disease
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irritable bowel
- ☐ Kidney stones
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Recurrent skin infections
- ☐ Recurrent UTI
- ☐ Seizures
- ☐ Sexually transmitted infections
- ☐ Stroke
- ☐ Thyroid diseases
- ☐ Vein problems
- ☐ Other diseases not listed _____
- ☐ Explain any of the above if necessary _____

_____

_____

- ☐ Hospitalizations _____

_____

Surgery/Procedures: (*check all that apply)*

- ☐ Appendix
- ☐ Bladder suspension
- ☐ Blood vessel surgery
  - ☐ Arteries
  - ☐ Veins
- ☐ Dental surgery
- ☐ Eye surgery
- ☐ Gallbladder
- ☐ Heart surgery
  - ☐ Bypass
  - ☐ Heart valve surgery
  - ☐ Angioplasty (balloon)
  - ☐ Stents
- ☐ Hysterectomy
  - ☐ Complete
  - ☐ Partial (ovaries preserved)
- ☐ Joint Replacement
- ☐ Orthopedic surgery
- ☐ Prostate surgery
- ☐ Tonsils and/or adenoids
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Other surgery not listed above _____
- ☐ Significant injuries _____

Medication List:

Name of medication, vitamin, OTC supplements or herbal medicine	Dosage	Supplies	Times/day	Disease or Reason

Medication allergies or reactions:

Medication	Reaction	Medication	Reaction
1		2	
3		4	

Name:_____

Family History:

Family Member	Date(s) of Birth	Living	Deceased	Diseases
Father				
Mother				
Brother(s) #				
Sisters(s) #				

Diseases in the family: Check all that apply

☐ Arthritis ☐ Addiction problems ☐ Bleeding Problems

Cancer(s) ☐ Colon ☐ Breast ☐ Prostate ☐ Other type of cancer(s) _____

☐ Depression/Anxiety ☐ Diabetes ☐ Heart disease ☐ High blood pressure

☐ High cholesterol ☐ Kidney disease ☐ Liver disease ☐ Mental illness

☐ Other

☐ Details / Other _____

_____

Social History:

Married? ☐ NO ☐ YES Divorced? ☐ NO ☐ YES Children? ☐ NO ☐ YES If yes, number of children _____

Family members living in the home: ☐ Mother ☐ Father ☐ Siblings ☐ Others: _____

Do you smoke? ☐ Currently ☐ Past ☐ Never _____ packs/day for _____ years. Other tobacco use? ☐ NO ☐ YES

If you do smoke, would you like information about our smoking cessation program? ☐ NO ☐ YES

Do you drink alcohol? ☐ NO ☐ YES ☐ Beer ☐ Wine ☐ Liquor. How many drinks per week? _____

How many servings of caffeine per day? _____ ☐ Coffee ☐ Tea ☐ Sodas

Do you limit salt in your diet? ☐ NO ☐ YES Do you limit fat? ☐ NO ☐ YES

Any illegal drug use? ☐ NO ☐ YES Type _____

Occupation _____Any known occupational exposures? _____

Do you exercise regularly? ☐ Yes ☐ No If so, how many times per week? _____ Type of exercise _____

Do you feel safe in your home? ☐ NO ☐ YES

Sexual Orientation? ☐ Not Applicable ☐ Heterosexual ☐ Homosexual

Preventative Care:

Date of last Colon and Rectal Cancer screening: _____ ☐ Rectal exam ☐ Sigmoidoscopy ☐ Colonoscopy

Date of last eye exam: _____ Have you had bone density (DEXA) exam? ☐ NO ☐ YES Date: _____

Do you use your seat belt? ☐ Yes ☐ No

Immunizations:	Date	**Immunizations:**	Date
Tetanus		Hepatitis A	
Influenza		Hepatitis B	
Pneumonia		Shingles	
Whooping cough		HPV	

For our FEMALE patients only:

Do you have a Gynecologist? ☐ Yes ☐ No If yes, Gynecologist name: _____

Date of last PAP test _____ Date of last mammogram _____ Do you do self-breast exams? ☐ Yes ☐ No

Have you gone through menopause? ☐ Yes ☐ No

Menstrual or period problems: ☐ Irregular ☐ Heavy ☐ Change in frequency _____

Number of pregnancies _____ Number of live births ____Vaginal ____ C-section ____ Miscarriages ____ # of abortions _____

Can you think of anything else that you think we should know about your health and lifestyle that is not listed here?

_____

For our MALE patients only: Date of last PSA test _____ Date of last rectal exam_____

Name:_____

Review of Systems:

Please indicate any problems in the following areas that are bothering you. If your planned visit is for a Preventative Physical, please be aware that another office visit may need to be scheduled to address new specific issues in appropriate detail.

Check all that apply:					
Constitutional:	☐ Fever	☐ Chills/Sweats	☐ Weight gain / Loss	☐ Fatigue	☐ Weakness
	☐ Poor appetite	☐ Appetite change			
Eyes:	☐ Blurred vision	☐ Double vision	☐ Eye pain		
Ears:	☐ Ear pain	☐ Decreased hearing	☐ Dizziness (light headed, room spinning)	☐ Ringing	
Nose:	☐ Congestion	☐ Sinusitis	☐ Difficulty breathing through nose	☐ Frequent nose bleeds	
Throat:	☐ Sore throat	☐ Sensation of fullness	☐ Difficulty swallowing		
Neck:	☐ Neck pain	☐ Fullness or lumps			
Cardiovascular:	☐ Chest discomfort (pain, pressure, fullness squeezing) with exertion or exercise			☐ Heart palpitations	
	☐ Heart racing	☐ Shortness of breath while lying down or with exertion (out of proportion to activity)			
	☐ Swelling of legs	☐ Fainting			
Pulmonary:	☐ Cough	☐ Emphysema (COPD)	☐ Shortness of Breath	☐ Asthma	
GI:	☐ Nausea	☐ Vomiting	☐ Abdominal pain		
	☐ Heartburn	☐ Sudden fullness	☐ Hemorrhoids		
	☐ Diarrhea	☐ Constipation	☐ Blood in stool	☐ Change in frequency of stools	
Genitourinary:	☐ Pain with urination	☐ Increased frequency of urination		☐ Frequent nighttime urination	
	☐ Blood in urine	☐ Sexual problems	☐ Difficulty with erections	☐ Vaginal pain	
	☐ Vaginal discharge	☐ Slow stream/dribbling	☐ Incontinence		
Musculoskeletal:	☐ Joint pains	☐ Muscle weakness	☐ Muscle pain	☐ Back pain	
Skin:	☐ Rash	☐ Sores	☐ Moles that are changing	☐ Itching	☐ Dry skin
	☐ Eczema	☐ Have seen dermatologist in past year	Dermatologist's name: _____		
Neurological:	☐ Headaches	☐ Numbness/Tingling	☐ Weakness	☐ Speech abnormalities	
	☐ Fainting	☐ Memory Problems	☐ Imbalance/vertigo	☐ Headaches	☐ Tremors
Psychological:	☐ Anxiety	☐ Eating disorder	☐ Obsessive behavior	☐ Depression	☐ Unusual fears
	☐ Mood swings	☐ Crying spells	☐ Lack of motivation	☐ Drug dependence	
	☐ Alcohol problems	☐ Insomnia	☐ Panic attacks	☐ Anger/Rage	

In the last 2 weeks, have you felt down, depressed or hopeless? ☐ Yes ☐ NO

In the last 2 weeks, have you felt little interest or pleasure in doing things? ☐ Yes ☐ NO

Do you have Advanced Directives (Living Will, Durable Medical Power of Attorney)? ☐ Yes ☐ NO

Reviewed with patient on _____ Signature _____

D.O.B_____ Office Use (P#)_____

CENTRAL OHIO PRIMARY CARE

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices at COPC which outlines my privacy rights and how COPC may use and disclose Protected Health Information about me.

□ Yes □ Offered but Decline Initials: _____

Photograph for Patient Identification

I give my consent to the use of my photograph for identification on my electronic health record. □ Accept □ Decline Initials: _____

Telephone Contacts, Monitoring and Recording-this does not include calls related to appointments, billing, or health-related information

I hereby consent and agree that: (1) any calls with COPC may be monitored and/or recorded and that COPC (or anyone acting on COPC's behalf) may contact me, from time to time, regarding my account (including for collections purposes or related to insurance coverage) or regarding my most recent visit with my provider; (2) any and all of COPC's contacts with me may be made via text message or with an automated dialing device; (3) COPC may contact me at any telephone number I provide to them, whether a residential, business number, or mobile number; (4) COPC may e-mail newsletters informing me of new services or suggested health screenings; and (5) I have an established business relationship with COPC and COPC may contact me in any of the ways described above. I understand that, if I accept now, I may opt-out at any time by notifying the COPC EHR Department.

□ Accept □ Decline Initials: _____

Health Information Exchange (HIE)

COPC participates in one or more Health Information Exchanges (HIEs) that share medical information to facilitate improved care through a comprehensive health record. This information is secure and only available to those providers involved in your care delivery. (For example, if you go to the Emergency Department, providers at the Emergency Department can pull your relevant health information from the HIE in order to better treat you.) I agree that my COPC provider may allow access to my health information through the Health Information Exchange for treatment or other health care operations. This is a voluntary agreement. I understand that I may opt-out at any time by notifying the Compliance Department via the HIE Opt-Out form located on the COPCP website.

Pursuant to Ohio law all patients are automatically enrolled in the HIE unless an opt-out form is completed and submitted to the Compliance Department. Please allow 10 business days for processing.

Confidential Communications

I understand COPC will notify me if COPC is unable to comply with my request for Confidential Communications.

Release of Protected Health Information in Emergency Situation

I understand that my protected health information may be released as my physician determines appropriate in an emergency situation.

Insurance Assignment and Acknowledgement

I understand my insurance carrier can choose to assign benefits to COPC or my Insurance carrier may make a payment directly to me. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charge for non-covered service provided to me or to any of my dependents. I am also responsible for providing up-to-date and accurate insurance information.

Medicare and Medicaid: *I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.*

I authorize any holder of medical or other information about me to release to the Social Security Administration, Medicare, Medicaid, and/or its intermediaries/carriers, as well as my commercial insurance carriers any and all information required for claim consideration and payment. I certify that I will pay to COPC any co-payments, co-insurance, deductibles or non-covered services. I will immediately pay to COPC any payments that I receive from my insurance carrier for services provided to me and/or my dependents. I will also be responsible for any amounts not paid by my insurance for my failure to provide the appropriate insurance information for billing.

By signing below, I am acknowledging that I have read and understand the above statements.

_____	_____	_____
Patient Printed Name	Patient Signature	Date Signed
_____	_____	_____
Legal Guardian Printed Name (*if applicable*)*	Legal Guardian Signature (*if applicable*)*	Date Signed

PLEASE PROVIDE A COPY OF LEGAL GUARDIANSHIP COURT PAPERS FOR THE PATIENT'S RECORD.

CENTRAL OHIO℠ PRIMARY CARE

Patient Name: _____ DOB: _____ Acct. #_____

Agreement of Financial Responsibility

Thank you for choosing ***Central Ohio Primary Care Physicians, Inc.*** (***COPC***) as your health care provider. COPC is committed to providing quality care and service to all of our patients. The following is a statement of COPC's financial policy, which we require that you read and agree to prior to receiving any treatment from COPC.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. COPC accepts cash, check, credit cards, and pre-approved insurance for which COPC is a contracted provider.

It is your responsibility to know your own insurance benefits, including:

- whether COPC is a contracted provider with your insurance company;
- your covered benefits and any exclusions in your insurance policy; and
- any pre-authorization requirements of your insurance company.

COPC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information to COPC, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by COPC.

If COPC has a contract with your insurance company, COPC will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If COPC does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. COPC will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of insurance and photo ID are required for all patients. COPC will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

Image Release

Date:_____

The undersigned hereby consents to and authorizes Central Ohio Primary Care Physicians, Inc. ("COPC") to use and reproduce photographs, video and/or any other digitally captured imagery ("Images") of the individual listed below, with or without my name and for any lawful purpose, including but not limited to such purposes as publicity, promotional, illustration, advertising, social medica and other Web content.

The undersigned acknowledges that no compensation will be made by COPC to the undersigned for COPC'S use of the Images.

The undersigned further acknowledges that the Images, whether printed or digital, of the individual listed below will reside in public domain and will be accessible by the general public.

Revocation of Consent: I understand that I may revoke this authorization, in writing, at any time and will not hold COPCP liable for the release of photographs/videotapes/other images that occurred prior to this revocation. Revocation must be made in writing and submitted to the COPC Marketing Department 655 Africa Road, Westerville, Ohio 43082.

The undersigned hereby releases COPC, its agents, employees and assigns from any and all claims related to COPC'S use of the Images.

Name (Print) _____

Signature _____

Parent Signature (if applicable) _____

Address _____

_____

_____

CENTRAL OHIO PRIMARY CARE

AUTHORIZATION TO DISCLOSE (RELEASE) PROTECTED HEALTH INFORMATION (PHI)

(Please Complete All Highlighted Sections to Avoid Any Delays in Processing)

Please Print

Patient's Name: _____ **Date of Birth:** _____ **Patient #** _____
Last **First** **Middle** **(M/D/Y)**

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

Phone Number: _____ **E-Mail Address:** _____ **Date(s) of Service:** _____

Purpose of Release:

- □ **Continuity of Care/Treatment**
- □ **Self/Personal Reasons**
- □ **Disability**
- □ **Leaving COPC Practice/Physician *(specify reason below)***
  - □ **My Insurance Coverage Changed**
  - □ **Move/Location Change**
  - □ **Patient Preference**
  - □ **Leaving Specialist**
- □ **Employment Related**
- □ **Provide to Insurance Company**
- □ **Transfer to other COPC practice/physician**
- □ **Research**
- □ **Legal Reasons**
- □ **Other (please specify):** _____

Physician Practice/Organization Authorized to **Release** Information:

Name: _____

Address: _____

City, State & Zip: _____

Fax #: _____ **Phone #:** _____

Person/Physician Practice/Organization Authorized to **Receive** Information:

Name: _____

Address: _____

City, State & Zip: _____

Fax #: _____ **Phone #:** _____

Information to be Released – For the record(s) selected above, specify the content to be released in the area below as Complete Record, Minimum Document Set or Additional Document Set. Each type of record may or may not contain all the documents listed.

□ **Complete Record**	□ **Minimum Documents** (the following will be sent) • **Progress Notes – last 2 years** • **Radiology (if applicable) – last 2 years** • **Lab (if applicable) –last 2 years** • **Other Diagnostic Tests (if applicable)-last 2yrs** • **Cardiovascular (if applicable) – last 2 years** • **Consultations – last 2 years** • **Hospital Records – last 2 years**	□ **Additional Documents** (comprised of Minimum Documents plus the following selected items): □ **Physician Orders** □ **Nurses Notes** □ **Graphics** □ **Physical Therapy** □ **Medication Lists** □ **Other/Misc:** _____

Method of Release:

□ **Mail** □ **Fax** □ **Other (please specify):** _____

Expiration: This authorization for release of protected health information for the date(s) of service indicated is effective until _____ or for a maximum of one year from the date signed below.

Revocation: I understand that I may revoke this authorization, in writing, at any time except to the extent that COPC has relied on this authorization to release protected health information. Revocation must be made in writing and submitted to the COPC Health Information Department, 655 Africa Road, Westerville, Ohio 43082.

Redisclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Fees: According to Ohio Revised Code, there is a per page fee for records. This fee will depend on the number of copies requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC.

COPC does not condition treatment, payment enrollment or eligibility for benefits on the signing of this authorization.

I hereby authorize the release of my health information from the Practice/Organization named above to the Recipient named above. I understand and acknowledge that this may include treatment for physical and mental illness, alcohol/drug abuse and or HIV/AIDS test results or diagnoses.

_____ _____
Signature of Patient **Date**

_____ _____ _____
Signature of Patient's Legal Representative **Relationship to Patient** **Date**

If signed by Patient's Legal Representative, please include a copy of the document authorizing your authority to act on behalf of the patient (e.g. health care power of attorney).

Form Revision: 11/21/13, 2/26/15, 6/6/2018, 3/30/2022