

 **PHYSICIAN CARE**
HAMPTON COVE

James Morrison Jr., MD
Tommie Robinson, MD
Kandess Anderson, CRNP
Briana Woodfin, CRNP

Dear Patient,

We would like to take this opportunity to thank you for choosing Huntsville Hospital Physician Care - Hampton Cove for your primary medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website should help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

Please call the office at (256) 265-0350 to schedule your new patient appointment prior to completing the New Patient Forms. Bring the completed forms with you on your appointment date, along with your identification cards, insurance cards, medication bottles, as well as your co-payments and/or deductibles.

We ask that all new patients arrive ***30 minutes*** prior to your appointment time, so you can be seen by the doctor at your scheduled time.

If you are unable to keep your appointment for any reason or if you are going to be ***15 minutes*** or more late, please call our office at (256) 265-0350 as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,



Carole Rundle
Practice Administrator
Huntsville Hospital Physician Care - Hampton Cove

*Russell Brown Medical Park
262 Sutton Road
Owens Cross Roads, AL 35763
(256) 265-0350
(256) 265-0357 fax*

HH PHYSICIAN CARE

HAMPTON COVE

262 Sutton Road
Owens Cross Roads, Alabama 35763
Phone: (256) 265-0350 Fax: (256) 265-0357

PATIENT INFORMATION

PLEASE PRINT

DATE _____

Patient's Name _____ Referred By _____
LAST FIRST MI

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Sex M F D.O.B. _____ / _____ / _____

Email Address _____

Patient's Occupation _____ Employer: _____

Employer's Address _____ Employer's Phone () _____

Spouse's Name _____ Spouse's D.O.B. _____ / _____ / _____ Spouse's SS # _____ - _____ - _____

Spouse's Occupation _____ Spouse's Employer _____

Employer's Address _____ Employer's Phone () _____

Notify in case of emergency _____ Relationship _____

City _____ State _____ Phone () _____

If patient is a minor, list persons other than responsible party above, who have permission to bring child to office for treatment:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

SECONDARY INSURANCE TO FILE

Policy #	Group #
Insured's Name	Relationship to Patient
Insured's Social Security # or I.D. #	Insured's Date of Birth
Insurance Company Name	

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE () _____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature _____ Date _____ Time _____

PHYSICIAN CARE

HAMPTON COVE

Huntsville Hospital Physician Care Hampton Cove

Medicare Secondary Payer Questionnaire

Patient Name: _____ **Patient DOB:** _____

Patient DOS: _____

Part I

1. Are you receiving Black Lung Benefits?
 - No
 - Yes – (Date Benefits began: _____) **Black Lung is Primary Only for Claims Related to Black Lung**
2. Are the services to be paid by the government program such as research grant?
 - No
 - Yes – **Government Program will be Primary**
3. Has the Department of Veterans Affairs authorized and agreed to pay for care at this facility?
 - No
 - Yes – **Department of Veterans Affairs is Primary**
4. Was the illness or injury due to work related accident or condition?
 - No – **Go to Part II**
 - Yes – (Date of Injury/Illness: _____) **Worker's Comp is Primary Go to Part III**

Part II

1. Was illness or injury due to non-work related accident?
 - No – **Go to Part III**
 - Yes – (Date of Accident: _____)
2. What type of accident caused the illness or injury?
 - Automobile – **Motor Vehicle Insurance is Primary**
 - Non-Automobile – **Go to question 3**
3. Was another party responsible for this accident?
 - No – **Go to Part III**
 - Yes – **Liability Insurance Carrier is Primary**

Part III

1. Are you entitled to Medicare based on:
 - Age – 65 and over – **Go to Part IV**
 - Disability – **Go to Part V**
 - Dialysis (End Stage Renal Disease) – **Go to Part VI**

Patient Name: _____

Patient DOB: _____

Patient DOS: _____

Part IV – Age

1. Are you currently employed?

- No (Date of Retirement: _____)
- Never Worked
- Yes

Employer Name: _____

Employer Address: _____

2. Is your spouse currently employed?

- No (Date of Retirement: _____)
- Never Worked
- Yes

Employer Name: _____

Employer Address: _____

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or a spouse's current employment?

- No – **Stop**
- Yes – **Go to Question 4**

4. Does the employer that sponsor's your Group Health Plan employ 20 or more employees?

- No – **Stop**
- Yes – **Stop Group Health Plan is Primary**

Part V – Disability

1. Are you currently employed?

- No (Date of Retirement: _____)
- Yes

Employer Name: _____

Employer Address: _____

2. Is a family member currently employed?

- No
- Yes

Employer Name: _____

Employer Address: _____

IF THE ANSWER TO BOTH QUESTIONS ABOVE ARE NO, MEDICARE IS PRIMARY. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan coverage based on your own or family member's current employment?

- No – **Stop**
- Yes – **Go to Question 4**

4. Does the employer that sponsors the Group Health Plan employ 100 or more employees?

- No – **Stop Medicare is Primary**
- Yes – **Stop Group Health Plan is Primary**

Patient Name: _____

Patient DOB: _____

Patient DOS: _____

Part VI – Dialysis (End Stage Renal Disease)

1. Do you have Group Health Plan coverage?
 - No – **Stop Medicare is Primary**
 - Yes
 - Employer Name: _____
 - Employer Address: _____
2. Have you received a kidney transplant?
 - No
 - Yes (Date of Transplant: _____)
3. Have you received maintenance dialysis treatments?
 - No
 - Yes (Date Dialysis Began: _____)
If you participated in a self dialysis training program provide date training started:

4. Are you within 30 month coordination period?
 - No – **Stop Medicare is Primary**
 - Yes
5. Are you entitled to Medicare on the basis of either End Stage Renal Disease and age or End Stage Renal Disease and Disability?
 - No – **Stop Group Health Plan is Primary During the 30 Month Coordination Period**
 - Yes
6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on End Stage Renal Disease?
 - No – **Initial entitlement based on age or disability**
 - Yes – **Stop Group Health Plan Continues to Pay Primary During 30 Month Coordination Period**
7. Does the working aged or disability Medicare Secondary Payer apply (i.e. is the Group Health Plan primary based on age or disability entitlement)?
 - No – **Medicare Continues to Pay Primary**
 - Yes – **Group Health Plan Continues To Pay Primary During 30 Month Coordination Period**

PHYSICIAN CARE

HAMPTON COVE

Pediatric History Form

Name: _____ DOB: _____ Date: _____

Reason for visit today: _____

Referred by: _____ Previous Family Physician: _____

It is the responsibility of the parents to provide a copy of the immunization record.

With whom does the child live? (please provide names and relationship)

Who is the legal guardian of the child? _____

Who is authorized to bring the child in for medical exams including immunizations?

With whom can we discuss the patients medical history by phone or during office visits?

Are the parents married / divorced / separated / unmarried / widowed (circle one)

Is there any legal reason why we cannot discuss the child's medical care with either parent?

EDUCATION/DEVELOPMENT/SOCIAL

Does your child attend day care? _____

What school does the child attend and which grade? (If home-schooled, please list below)

Does the child receive any special services such as Physical Therapy, Speech Therapy, Occupational Therapy, or Special Education services? _____

Does the child have any behavioral, social or learning problems? _____

Does the child participate in any organized sports or hobbies? _____

Are there any smokers in the house? Yes / No

FAMILY HISTORY

Is there any family history of the following:

Diabetes

High Blood Pressure

Childhood Heart Disease

Asthma

Allergies

Learning problems

Seizures

Sickle Cell Anemia

Birth Defects

Sudden Death

Please list any other pertinent Family Medical History:

MEDICAL HISTORY

Please list the child's medical problems. Circle all that apply.

Asthma Allergic Rhinitis Attention Deficit Disorder (ADD) Migraines Seizures Heart Murmur

Please continue on other side

Patient Name: _____ DOB: _____

Has the child ever been hospitalized? If so, for what and when?

Has the child ever had any surgeries? Circle all that apply.

Appendectomy Tonsillectomy Adenoidectomy Tubes in ears Gall bladder Orthopedic

What medications does the child take?

Does the child have any medication allergies? If so, what is his/her reaction?

What specific health concerns do you wish to address today?

Do you have any concern about your safety or your child's safety? Yes / No

FOR TEEN GIRLS:

Have you started your period? If so, at what age? _____ Are your periods every month? _____

How long do they last? _____ Are they painful? _____

FOR TEEN BOYS AND GIRLS:

Do you smoke? _____ Drink alcohol? _____ Use illicit drugs? _____

Are you sexually active? _____ If so, do you practice "safe sex"? _____

Have you ever been pregnant? _____ Had a child? _____

What are your long term goals for the future? _____

What talents do you have which give you joy and a sense of accomplishment? _____

DIETARY HISTORY (all ages):

Please write down everything the child has eaten or drank in the last 24 hours.

Name of person completing this form and relationship _____

DATE: _____

APPT. TODAY WITH:

Allada Woodfin Morrison

NAME: _____

WHAT OTHER DOCTORS/SPECIALIST DO YOU SEE:

DATE OF BIRTH: _____

NAME/SPECIALTY _____

AGE: _____

REASON FOR VISIT: _____

ANY NEW OR WORSENING PROBLEMS? IF YES, PLEASE DESCRIBE: _____

PLEASE CHECK IF YOU HAVE ANY OF THE BELOW:

PAST MEDICAL HISTORY:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> CROHN'S DISEASE | <input type="checkbox"/> HEPATITIS A | <input type="checkbox"/> THYROID DISORDER |
| <input type="checkbox"/> ATRIAL FIBRILLATION | <input type="checkbox"/> CHRONIC RENAL FAILURE | <input type="checkbox"/> HEPATITIS B | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HEPATITIS C | <input type="checkbox"/> VALVULAR HEART DISEASE |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> DIABETES - JUVENILE ONSET | <input type="checkbox"/> INFERTILITY | <input type="checkbox"/> UTI - RECURRENT |
| <input type="checkbox"/> AUTOIMMUNE DISEASE (LUPUS) | <input type="checkbox"/> DIABETES - ADULT ONSET | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> VARICOSE VEINS/PHLEBITIS |
| <input type="checkbox"/> BILIARY CIRRHOSIS | <input type="checkbox"/> DIVERTICULITIS | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> ABNORMAL PAP SMEAR |
| <input type="checkbox"/> BLOOD TRANSFUSION | <input type="checkbox"/> DVT (BLOOD CLOT IN LEGS) | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> BREAST DISEASE |
| <input type="checkbox"/> BRAIN TUMOR | <input type="checkbox"/> GI BLEED | <input type="checkbox"/> MI (HEART ATTACK) | <input type="checkbox"/> BREAST CANCER |
| <input type="checkbox"/> CEREBROVASCULAR | <input type="checkbox"/> GERD (ACID REFLUX) | <input type="checkbox"/> NEUROLOGIC DISORDER | <input type="checkbox"/> CERVICAL CANCER |
| <input type="checkbox"/> DISEASE (STROKE) | <input type="checkbox"/> HEMOCHROMATOSIS | <input type="checkbox"/> OSTEOARTHRITIS | <input type="checkbox"/> DES EXPOSURE |
| <input type="checkbox"/> CIRRHOSIS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> OSTEOPOROSIS | <input type="checkbox"/> GESTATIONAL DIABETES |
| <input type="checkbox"/> CVA/STROKE | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> PVD | <input type="checkbox"/> RH SENSITIZED |
| <input type="checkbox"/> COPD (LUNG DISEASE) | <input type="checkbox"/> HYPOTHYROIDISM | <input type="checkbox"/> PUD (STOMACH ULCERS) | <input type="checkbox"/> SLEEP APNEA |
| <input type="checkbox"/> COLON CANCER | <input type="checkbox"/> HYPERTHYROIDISM | <input type="checkbox"/> RHEUMATOID ARTHRITIS | ***USING CPAP YES/NO |
| <input type="checkbox"/> CORONARY HEART DISEASE | <input type="checkbox"/> GOITER | <input type="checkbox"/> SEIZURE DISORDER | |

OTHER _____

PAST SURGICAL HISTORY:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AMPUTATION | <input type="checkbox"/> COLON RESECTION | <input type="checkbox"/> PACEMAKER IMPLANTED | <input type="checkbox"/> BREAST AUGMENTATION RIGHT/LEFT |
| <input type="checkbox"/> AV FISTULA CREATION | <input type="checkbox"/> CRANIOTOMY | <input type="checkbox"/> PARATHYROIDECTOMY | <input type="checkbox"/> MASTECTOMY RIGHT/LEFT |
| <input type="checkbox"/> AV GRAFT | <input type="checkbox"/> GASTRIC BYPASS | <input type="checkbox"/> PNEUMONECTOMY | <input type="checkbox"/> LUMPECTOMY RIGHT/LEFT |
| <input type="checkbox"/> AORTIC VALVE REPLACEMENT | <input type="checkbox"/> HEMORRHOIDECTOMY | <input type="checkbox"/> PTCA (ANGIOPLASTY) | |
| <input type="checkbox"/> AORTIC VALVE REPLACED | <input type="checkbox"/> HIP REPLACEMENT | <input type="checkbox"/> ROTATOR CUFF REPAIR | |
| <input type="checkbox"/> APPENDECTOMY | <input type="checkbox"/> INVASIVE PAIN PROCEDURE | <input type="checkbox"/> ABD. HYSTERECTOMY | |
| <input type="checkbox"/> BOTH LEGS BYPASSED | <input type="checkbox"/> KIDNEY TRANSPLANT | <input type="checkbox"/> HYSTERECTOMY/OVARIES | |
| <input type="checkbox"/> BACK SURGERY | <input type="checkbox"/> KNEE ARTHROSCOPY | <input type="checkbox"/> **OVARIES REMOVED YES/NO | |
| <input type="checkbox"/> BRONCHOSCOPY (LUNG SCOPE) | <input type="checkbox"/> KNEE REPLACEMENT | <input type="checkbox"/> PROSTATE SURGERY | |
| <input type="checkbox"/> CABG (HEART BYPASS) | <input type="checkbox"/> KYPHOPLASTY | <input type="checkbox"/> SHOULDER SURGERY | |
| <input type="checkbox"/> CAROTID ENDARTERECTOMY | <input type="checkbox"/> LUMPECTOMY | <input type="checkbox"/> SLEEP APNEA SURGERY | |
| <input type="checkbox"/> CARPAL TUNNEL | <input type="checkbox"/> MASTECTOMY | <input type="checkbox"/> THYROID SURGERY | |
| <input type="checkbox"/> CATARACT EXTRACTION | <input type="checkbox"/> MITRAL VALVE REPLACED | <input type="checkbox"/> TONSIL'S REMOVED | |
| <input type="checkbox"/> GALLBLADDER REMOVED | <input type="checkbox"/> NEPHRECTOMY | <input type="checkbox"/> VASCULAR SURGERY | |

OTHER _____

FAMILY HISTORY:

Patient name: _____ DOB: _____

	FATHER	MOTHER	BROTHER	SISTER	CHILDREN
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HEART ARTERY DISEASE/HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASE (CHRONIC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THYROID DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CANCER (TYPE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER: _____

SOCIAL HISTORY: (CHECK OR CIRCLE APPROPRIATE)

MARRIED/SINGLE/DIVORCED/WIDOWED

RELIGIOUS AFFILIATION _____

WORKS PART-TIME/ FULL-TIME

OCCUPATION: _____

RETIRED

DISABLED

CHILDREN - YES OR NO

ALLERGIES OR MEDICATION REACTIONS:

NO KNOWN DRUG ALLERGIES

ALLERGIC TO: _____

REACTION: _____

RISK FACTORS: (CHECK OR CIRCLE APPROPRIATE)

CURRENT TOBACCO USE YEAR STARTED: _____

CAFFEINE USE YES NO

TYPE OF TOBACCO: (CIRCLE APPROPRIATE)

HOW MANY DRINKS PER DAY _____

CIGARETTES, CIGARS, SNUFF, VAPOR

ALCOHOL USE YES NO

FORMER TOBACCO USE YEAR QUIT: _____

HOW MANY PER DAY _____

NEVER SMOKED

TYPE: _____

SECOND HAND SMOKE YES NO

HOW MANY DRINKS PER DAY _____

DO YOU WEAR YOUR SEAT BELT? YES NO

EXERCISE YES NO

TIMES PER WEEK: _____

TYPE: _____

CURRENT MEDICATIONS:

REFER TO LIST

REFER TO BOTTLES

PLEASE INCLUDE THE DOSE AND HOW OFTEN YOU TAKE THE MEDICATION (NO NEED TO LIST BELOW IF YOU BROUGHT A LIST OR BOTTLES)

NAME	DOSAGE	HOW MANY TIMES PER DAY	AS NEEDED (PRN)

MEDICAL PROBLEMS: HAVE YOU HAD ANY RECENT OR PERSISTENT PROBLEMS WITH THE FOLLOWING?

General: <input type="checkbox"/> WEIGHT GAIN / LOSS <input type="checkbox"/> DIABETES <input type="checkbox"/> BACK PAIN	Skin: <input type="checkbox"/> RASHES <input type="checkbox"/> NAIL / HAIR PROBLEMS <input type="checkbox"/> ABDOMINAL MOLES	Extremities: <input type="checkbox"/> JOINT PAIN <input type="checkbox"/> GOUT <input type="checkbox"/> VARICOSE VEINS <input type="checkbox"/> LEG SWELLING	Neck: <input type="checkbox"/> GOITER <input type="checkbox"/> SWOLLEN GLANDS <input type="checkbox"/> THYROID
Mouth: <input type="checkbox"/> DENTURES <input type="checkbox"/> HOARSENESS <input type="checkbox"/> GUMS LAST DENTAL EXAM: _____ DENTIST: _____	Heart: <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> CONGESTIVE HEART FAILURE <input type="checkbox"/> HEART MURMUR <input type="checkbox"/> PALPITATIONS LAST EKG: _____	Gastrointestinal: <input type="checkbox"/> TROUBLE SWALLOWING <input type="checkbox"/> REFLUX / GERD <input type="checkbox"/> VOMITING <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> BLOODY / BLACK STOOL <input type="checkbox"/> HEMORRHOIDS <input type="checkbox"/> HEPATITIS LAST COLONOSCOPY: _____	Urinary: <input type="checkbox"/> FREQUENCY <input type="checkbox"/> TROUBLE STARTING OR STOPPING <input type="checkbox"/> URINARY PAIN <input type="checkbox"/> URINATE AT NIGHT <input type="checkbox"/> LEAKAGE <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> KIDNEY STONES <input type="checkbox"/> INFECTIONS <input type="checkbox"/> PROSTATE TROUBLE
Neuro: <input type="checkbox"/> HEADACHE <input type="checkbox"/> HEAD INJURY <input type="checkbox"/> BLACKOUTS / DIZZY <input type="checkbox"/> SEIZURES / TREMORS <input type="checkbox"/> MEMORY LOSS <input type="checkbox"/> DEPRESSION / ANXIETY	Lungs: <input type="checkbox"/> PERSISTANT COUGH <input type="checkbox"/> COUGH UP BLOOD <input type="checkbox"/> EMPHYSEMA / BRONCHITIS <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> PNEUMONIA	Lifestyle: <input type="checkbox"/> REGULAR EXERCISE _____ TIMES A WEEK <input type="checkbox"/> LOW SALT DIET <input type="checkbox"/> LOW FAT DIET	Sexual: <input type="checkbox"/> PROBLEMS WITH SEX <input type="checkbox"/> MULTIPLE PARTNERS <input type="checkbox"/> HISTORY OF STD <input type="checkbox"/> HIV
ENT: <input type="checkbox"/> ALLERGIES <input type="checkbox"/> SINUS TROUBLE <input type="checkbox"/> HEARING LOSS <input type="checkbox"/> GLASSES / CONTACTS <input type="checkbox"/> BLURRED VISION <input type="checkbox"/> RINGING LAST EYE EXAM: _____ EYE DOCTOR: _____	Women: <input type="checkbox"/> IRREGULAR PERIODS <input type="checkbox"/> PELVIC PAIN <input type="checkbox"/> BIRTH CONTROL PILLS <input type="checkbox"/> NIPPLE DISCHARGE <input type="checkbox"/> LUMPS IN BREASTS <input type="checkbox"/> SELF BREAST EXAM		

PLEASE ENTER THE MOST RECENT DATE AND RESULTS OF THE FOLLOWING:

	DATE	RESULTS	PERFORMED BY WHO/WHERE
COLONOSCOPY	_____	_____	_____
PAP SMEAR	_____	_____	_____
MAMMOGRAM	_____	_____	_____
BONE DENSITY SCAN	_____	_____	_____
MENSTRUAL PERIOD	_____	_____	_____
PSA (PROSTATE SCEEN)	_____	_____	_____

WHEN WAS YOUR LAST VACCINE ON THE FOLLOWING:

	DATE	Would you like one?
FLU VACCINE	_____	Yes / No
TETANUS VACCINE	_____	Yes / No
PNEUMONIA VACCINE	_____	Yes / No
ZOSTAVAX	_____	Yes / No

PHYSICIAN CARE HAMPTON COVE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional) _____
 Date of Birth _____ Address _____
 Phone Number (____) _____ Date(s) of Service _____

Chart Number _____
 Provider _____

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital Physician's Network is authorized to make the disclosure.
2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> All /Entire Record	<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Records Release Format (Choose one) <input type="checkbox"/> e-delivery (HealthPort Connect) <input type="checkbox"/> CD <input type="checkbox"/> Paper
<input type="checkbox"/> Visit/Encounter Notes	<input type="checkbox"/> Consultation Report	
<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Operative Report	
<input type="checkbox"/> X-Ray and Imaging Reports	<input type="checkbox"/> Immunization Record	
<input type="checkbox"/> Problem list	<input type="checkbox"/> Drug and Alcohol Treatment	
<input type="checkbox"/> Medication List	<input type="checkbox"/> HIV/AIDS/STD Treatment	
<input type="checkbox"/> Allergies List	<input type="checkbox"/> Registration Record	
<input type="checkbox"/> EKG Report	<input type="checkbox"/> Other _____	
3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
4. This information may be disclosed to, and used by, the following individual or organization:
 Name: _____
 Address: _____
5. For the purpose of _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

 If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.
8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.
9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.
10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

Or

I understand that if I refuse to sign this form, under specific conditions the organization can refuse:

Treatment Enrollment in the health plan Eligibility for benefits

SIGNATURE	DATE	TIME
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS	DATE
		TIME

For Office Use Only

Any portion of the record request found in paper chart?	YES	NO	(Please circle one)
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PHYSICIAN CARE

HAMPTON COVE

132 REQUEST FOR HEALTH INFORMATION FROM HOSPITALS OR OTHER PROVIDERS

Name of Organization/Person: _____

Address _____

Fax/Phone _____

Huntsville Hospital Requests Information for the Following Patient:

Patient Name _____ SS# (Optional) _____

Date of Birth _____

Address _____

Phone _____ Date of Service _____

Signature: _____

Patient Number

Requested information for treatment, payment, or operations:

- | | | |
|---|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Report | <input type="checkbox"/> Outpatient Record |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> EKG Report | <input type="checkbox"/> Emergency Dept Record |
| <input type="checkbox"/> Operative Note | <input type="checkbox"/> Nurses' Notes | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Imaging Results |
| | <input type="checkbox"/> Physicians' Orders | <input type="checkbox"/> Other _____ |

Please send to:

HH Physicians Care Hampton Cove
262 Sutton Road
Owens Cross Roads, AL 35763
Phone: (256) 265-0350 Fax: (256) 265-0357

Signature: _____

Date: _____

Relationship to Patient: _____

Witness: _____



Huntsville Hospital Physician Care at Hampton Cove

