AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBER OR OTHER PERSONS

Patient Name: _____ Address: _____

Date of Birth: _____

Phone #: ( ) _____

PRIVACY QUESTIONAIRE

1. Please list the names of the family members or other persons, if any, whom we may inform about your
   ____ Medical Condition, Diagnosis, or Lab reports ____ billing inquiries on your account
   We require three identifiers on each person listed, this is to ensure that we are giving the information to the appropriate person.

   Name: _____ Relationship to patient: _____
   Please give three identifiers: SS #_____ Date of Birth_____ Mother's Maiden Name _____

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2. Can confidential messages (i.e., appointment & outpatient service reminders) be left with a family member that answers your home phone? _____ YES _____ NO

3. Can confidential messages (i.e., appointment & outpatient service reminders) be left on your home phone answering machine or voicemail? _____ YES _____ NO

4. Please list the telephone number, if any, where you want to receive calls about your appointments, lab & x-ray results, or other health care information.
   Telephone Number: ( ) _____
   This is my (circle one): HOME / WORK / CELL / OTHER

STATEMENTS OF UNDERSTANDING

1. I authorize the release of information contained in my patient records, including alcohol and drug abuse protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, Behavioral Health, if any, HIV/AIDS related records, if any, and social services records, if any, including communications made by me to a social worker, to the individuals or organizations listed above, only under the conditions listed below.

2. I understand that if a person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above could be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

3. I understand that treatment or payment for services rendered cannot be conditioned on the signing of this authorization, excepting the instance of research related treatment or when the provision of healthcare to me is solely for the purpose of creating protected health information of disclosure to a third party.

4. I understand that this consent is subject to revocation at anytime. I understand that if I revoke this authorization, I must do so in writing and obtain and file a revocation form with the HIM Department of the entity authorized to release this information. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy.

5. This authorization will expire 1 year from date filled out, unless otherwise revoked. If this authorization is for a use or disclosure of PHI.

6. Allegiance Health will strive to meet your health information needs, but does reserve the right to receive reasonable notice of request and reasonable time to complete request.

_____ _____
(Signature of Witness) (Signature of Patient)

Date: _____ Date: _____

ADULT HISTORY INTAKE

Name:_____ Birth Date:_____ Age:_____ Today's Date:_____

Patient / Family History:
Have you or any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Self	Which Family Member (s)	Age When Diagnosed
Cancer (describe type)			
Hypertension (high blood pressure)			
Heart Disease			
Diabetes			
Stroke (s)			
Mental Disease (Anxiety, Depression, etc.)			
Drug or Alcohol Addiction			
Glaucoma			
Bleeding Diseases			
Osteoporosis			
Asthma			
Gastrointestinal Problems(Ulcer, Reflux, etc.)			
Kidney Problems			
Other_____			

List Operations/Hospitalizations and dates:_____

List any Injuries or Fractures and dates:_____

Medications:_____

Allergies:_____

PREVENTION/SOCIAL HISTORY

Occupation:_____

Do you smoke? Yes No
Do you drink alcoholic beverages? Yes No
Do you take drugs? Yes No
Have you fallen at home recently? Yes No
Do you drink coffee or tea? Yes No
Have you ever worked with chemicals, paints, Asbestos, and any other hazardous materials? Yes No

Do you have difficulty bathing, dressing, or feeding yourself? Yes No
Are you in a relationship in which you have been physically hurt by your partner? Yes No
Have you ever engaged in any activity which has put you at risk for getting AIDS? Yes No
Do you wish to be tested? Yes No

Females Only: Date of last mammogram:_____ Date of last menstrual period:_____

Reviewed By:_____ Date:_____
Reviewed By:_____ Date:_____
Reviewed By:_____ Date:_____
Reviewed By:_____ Date:_____

Review of Systems: Please indicate personal history below:

Patient Name:_____ Date of Birth:_____ Date:_____

Constitutional Symptoms:
Good general health lately ..... No Yes
Recent weight change..... No Yes
Fatigue..... No Yes
Headaches ..... No Yes
Fever..... No Yes

Ears/Nose/Mouth/Throat:
Hearing loss or ringing..... No Yes
Earaches or drainage..... No Yes
Chronic sinus problems or rhinitis... No Yes
Nose bleeds..... No Yes
Mouth sores..... No Yes
Bleeding gums..... No Yes
Bad breath or bad taste..... No Yes
Sore throat or voice change..... No Yes
Swollen glands in neck..... No Yes

Eyes:
Eye disease or injury..... No Yes
Wear glasses/contact lenses..... No Yes
Glaucoma..... No Yes
Double/Blurred Vision..... No Yes

Cardiovascular:
Difficult Urination..... No Yes
Heart trouble..... No Yes
Chest pain or angina pectoris..... No Yes
Palpitation..... No Yes
Shortness of breath walking/lying flat.. No Yes
Swelling of feet, ankles or hands..... No Yes

Respiratory:
Chronic or frequent cough..... No Yes
Spitting up blood..... No Yes
Shortness of Breath..... No Yes
Asthma or Wheezing..... No Yes

Gastrointestinal:
Loss of appetite..... No Yes
Change in bowel movement..... No Yes
Nausea or vomiting..... No Yes
Frequent diarrhea..... No Yes
Painful bowel movements..... No Yes
Constipation..... No Yes
Rectal bleeding or blood in stool..... No Yes
Abdominal Pain..... No Yes
Peptic Ulcer (stomach or duodenal)..No Yes

Hematologic/Lymphatic:
Slow to heal after cuts..... No Yes
Bleeding or bruising tendency..... No Yes
Anemia..... No Yes
Phlebitis..... No Yes
Past transfusion..... No Yes
Enlarged glands..... No Yes

Allergic/Immunologic:
History of skin or adverse reaction to:
Penicillin or other antibiotics..... No Yes
Morphine, Demerol, or other narcotics..No Yes
Latex..... No Yes
Aspirin or other pain remedies..... No Yes
Tetanus antitoxin or other serums..... No Yes
Iodine, methloate or other antiseptic..... No Yes
Other drugs/medications..... _____
Food Allergies..... _____
Environmental allergies..... _____

Genitourinary:
Frequent urination..... No Yes
Burning or painful urination..... No Yes
Blood in Urine..... No Yes
Change in force/strain when urinating... No Yes
Incontinence or dribbling..... No Yes
Kidney Stones..... No Yes
Sexual difficulty..... No Yes
Male – testicle pain..... No Yes
Female-painful/irregular periods..... No Yes
Female-vaginal discharge..... No Yes
Female-# of pregnancies..... _____
Female-# of miscarriages..... _____
Female-date of last pap smear..... _____

Musculoskeletal:
Joint pain..... No Yes
Joint stiffness or swelling..... No Yes
Weakness of muscles or joints..... No Yes
Muscle Pain or cramps..... No Yes
Back Pain..... No Yes
Cold extremities..... No Yes
Difficulty in walking..... No Yes

Integumentary: (skin, breast)
Rash or itching..... No Yes
Change in skin color..... No Yes
Change in hair or nails..... No Yes
Varicose Veins..... No Yes
Breast pain..... No Yes
Breast lump, discharge..... No Yes
Breast discharge..... No Yes

Neurological:
Frequent or recurring headaches..... No Yes
Light headed or dizzy..... No Yes
Convulsions or seizures..... No Yes
Numbness or tingling sensations..... No Yes
Tremors..... No Yes
Paralysis..... No Yes
Stroke..... No Yes
Head Injury..... No Yes

Psychiatric:
Memory loss or confusion..... No Yes
Nervousness..... No Yes
Depression..... No Yes
Insomnia..... No Yes

Endocrine:
Glandular or hormone problem..... No Yes
Thyroid disease..... No Yes
Diabetes (*Insulin or non-insulin-circle*)..No Yes
Excessive thirst or urination..... No Yes
Heat or cold intolerance..... No Yes
Skin becoming dryer..... No Yes
Change in hat or glove size..... No Yes

Reviewed By:_____ Date:_____
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