RANDOLPH
CARDIOLOGY

Authorization Form Policy

Effective date of policy: _____

Protected health information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, except for treatment, payment, or health care operations (TPO) and as otherwise required by law. Examples of some instances in which we are required to disclose your PHI include:
Public health activities; information regarding victims of abuse, neglect, or domestic violence; health oversight activities; judicial and administrative proceedings; law enforcement purposes; organ donations purposes; research purposes under certain circumstances; national security and intelligence; correctional institutions; and Worker's Compensation.

Randolph Cardiology will only use or disclose PHI, except as noted above, consistent with the terms of the authorization.

A patient may revoke his authorization to use or disclose PHI at any time but actions taken prior to the revocation are excluded. If authorization is a condition of obtaining insurance coverage, and the authorization is revoked, the insurer may contest a claim under the policy.

Authorizations must be properly executed by the patient or his personal representative. It should include, the date signed, specific PHI to be released or used, to whom this use or release relates, and an expiration date for the authorization.

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Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. *I authorize the use or disclosure of the above named individual's health information as described below.*
2. *The following individual or organization is authorized to make the disclosure:*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).
   - _____ Complete health records
   - _____ Lab results/X-ray reports
   - _____ Physical exam
   - _____ Consultation reports
   - _____ Immunization record
   - _____ Other (please specify): _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, 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.
5. *This information may be disclosed to and used by the following individual or organization.*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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 health information management department. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

   _____,

   Privacy Officer for _____.

_____ _____

Signature of patient or legal representative | Signature of witness

Date: _____ Date: _____

PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.

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PATIENT INFORMATION SHEET

Date _____ Social Security # _____

Last Name _____ First Name _____

Middle Initial _____ Date of Birth _____

Address _____ Home phone ( ) _____

_____ Cell phone ( ) _____

City, State, Zip _____ Other phone ( ) _____

Gender: ❑ Female ❑ Male

Marital status: ❑ Married ❑ Single ❑ Other

May we leave lab results on your home voicemail / answering machine? ❑ Yes ❑ No

May we leave lab results on your cell phone voicemail? ❑ Yes ❑ No

Emergency contact name _____

Relationship to you _____

Emergency contact phone numbers _____

Do you currently have health insurance? ❑ Yes ❑ No

Name of insurance company _____

Type of insurance plan ❑ HMO ❑ PPO ❑ POS ❑ Other

If you have an HMO, who is your primary care physician? _____

If you are not the insurance subscriber, please provide the following subscriber information:

Subscriber's Name _____

Address _____

_____

Policy # _____ Social Security # _____

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PATIENT HISTORY FORM

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

Past Medical History

Previous Physician's name: _____ Date of last exam: _____

Have you ever been hospitalized? ☐Yes ☐No If yes, what for? _____

Have you ever been tested for hepatitis A, B or C? ☐Yes ☐No Which hepatitis virus? _____

Have you been vaccinated for hepatitis B? ☐Yes ☐No If yes, date vaccine series completed _____

Have you been vaccinated for hepatitis A? ☐Yes ☐No If yes, date vaccine series completed _____

Last Tuberculosis (TB) Screening? _____ Result of TB screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray: _____ Result of chest x-ray: ☐Positive ☐Negative

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina	☐Shortness of breathe	☐Eye disorder / Glaucoma	☐Diabetes
☐High cholesterol	☐Asthma	☐Seizures	☐Kidney / Bladder problems
☐High blood pressure	☐Lung problems / cough	☐Stroke	☐Liver problems / Hepatitis
☐Low blood pressure	☐Sinus problems	☐Headaches / Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological problems	☐Cancer
☐Anemia or blood problems	☐Tonsillitis	☐Depression / Anxiety	☐Ulcers/colitis
☐Swollen ankles	☐Ear problems	☐Psychiatric care	☐Thyroid problems

Please describe any current or past medical treatment not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No

Please list: _____

Medications

Please list: _____

_____

PLEASE COMPLETE REVERSE SIDE →

Social and Preventive History

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐Yes ☐No

Do you use seatbelts while driving? ☐Yes ☐No Do you wear a helmet while riding a bike? ☐Yes ☐No

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐Yes ☐No	_____	_____
Father	☐Yes ☐No	_____	_____
Sisters	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
Brothers	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease / AIDS	_____
Mental Illness / Depression	_____
Stroke	_____
Other serious illness	_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

Name _____
MR#_____
DATE#_____

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

If you scored:

1 - 6	Congratulations, you are getting enough sleep!
7 - 8	Your score is average
9 and up	Seek the advice of a sleep specialist without delay