

ORG#	
MRN#	

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Patient

	Patient Patient	Parent/Responsible Party- if different Patient Relationship
Legal Last Name		
Legal First Name, Middle		
Nick Name		
SSN		
Date of Birth		
Sex	☐ Male ☐ Female	
Marital Status	☐ Single ☐ Married ☐ Divorced ☐ Widow	
Address		
Apt/Bldg/Suite #		
City, State, Zip		
Home Phone		
Work Phone		
Mobile Phone		
Email Address		
Employer Name		
Address		
City, State, Zip		
	Emergency Contact	Reason for visit
Name		
Home Phone		
Work Phone		Who referred you?
Mobile Phone		Permission to leave voice mail @ primary phone number?
	Primary Insurance	Secondary Insurance
Insurance Company		,
Primary Policyholder Name		
Primary Policyholder DOB		
Primary Policyholder Sex	☐ Male ☐ Female	
Primary Care Physician		If none, do you need help finding a Primary Care Physician? ☐ Yes ☐ No

Authorization, Assignment of Benefits, and Referral Medical Release

I hereby authorize the release of medical information including complete medical records, test results, and billing information to my insurance company, and to other medical professionals and medical care institutions that I may be referred to for treatment. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution. I authorize payment directly to Carolinas Physicians Network for all medical or surgical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. A photocopy of this authorization shall be considered as effective and as valid as the original.

Signed:	Date:
CHS-020 (8/07)	

Spouse/Significant Other Name: What is the reason for your visit today? What is the reason for your visit today? Vaccines In the teason for your visit today? Approximate Date Exams Last Dental exam Last Eye exam Plant	Date		Adult Pa	itient Histor	2	
Martial Status: Single Married Widowed Divorced Occupation: Spouse / Significant Other Name						
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Exercise regularly		1 U				
Have diet restrictions		***************************************				
	Travel outside US					

One Patient Per Authorization Form

Carolinas HealthCare System - CPN Ongoing Communications Authorization for Release of Health Information Form

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations once it is disclosed.

PURPOSE OF RELEASE: Ongoing Communication regarding your healthcare.		
RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information:		
Facility/Practice Name: Telephone #:		
DATES OF SERVICE, RANGE OF TIME OR EVENT(S): The facility/practice/individual listed above is authorized to release the requested health information listed below for the following: date(s) of service, range of time or events(s): From: (MM/DD/YY) Beginning of treatment To: (MM/DD/YY) End of Treatment This authorization will expire when the requested health information (as noted below), for the requested date(s) of service, range of time or event(s) (as noted above), is released to the recipient named in this document and the purpose of the release is satisfied.		
CHECK THE SPECIFIC INFORMATION TO BE RELEASED:		
☐ All Records & Details ☐ Other (Please Specify)		
I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).		
NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:		
Patient Name:		
First Middle/Maiden Last Patient Address:		
(Street Address PO Box, City, State, Zip) Social Security #1		
Social Security #: Date of Birth: Medical Record/Chart # Please provide phone numbers where you are authorizing CHS to leave patient information as described above:		
Home:		
Name Address Telephone/Fax # Retationship		
PATIENT'S RIGHTS AND SIGNATURE:		
 I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization. I understand that I may request to inspect or obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy 		
Practices/Policy. I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as an employer for a return to work evaluation, an insurance company for eligibility, or a research project in which I am participating. If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.		
PRINT NAME (Patient/Authorized Representative):		
SIGNATURE: DATE:		
If Authorized Representative, please indicate relationship to patient: Spouse Parent Guardian Executor of Estate Power of Attorney		
MINOR'S SIGNATURE: Please note, if the minor consents (no guardian is present to consent) for their own treatment for pregnancy, venereal disease, or emotional disturbance, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment. NAME OF MINOR: DATE:		



ACKNOWLEDGEMENT FORM

	Medical Records #
Patient's Name:	Date of Birth/
how we use and disclose your	vide you with our Notice of Privacy Practices which explain health information. We are also required to obtain your this notice has been made available to you.
Signature:	Date:
Signature:(Patient or Auth	orized Representative)
Relationship to Patient:	Self Spouse Other
Reason Patient Unable/Unwil	ling to Sign:
DOCOMENTO DE RECO	NOCIMIENTO DE CAROLINAS PHYSICANS NETWORK Numero de Registro Medico
Nombre del Paciente	Fecha de Nacimiento / / Dia Mes Ano
Privacidad las cuales explican	ros le proveamos a usted con nuestro Aviso de Practicas de como podemos usar y divulgar su informacion medica. La obtengamos su firma, reconociendo que este aviso lo hemos
Firma:(Paciente o Representa	The Autorizado)
Relacion al Paciente:	Mismo Esposo (a) Otro
Razon Por la Cual El Paciente	No Puede/No Desea Firmar: