Authorization for Release of Health Information

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630

_____FRFP to Send Records
_____FRFP to Request Records

Patient's Name: _____ **Requested Date**: _____

Date of Birth: _____ **Medical Record Number**: _____

1. I authorize the use and/or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to disclose and to receive my health information:

Doctors Name: _____

Address: _____

City, State and Zip Code: _____

Phone Number: _____ **Fax**: _____

3. The type and amount of information to be used or disclosed is as follows: (Include dates where appropriate)

_____ Problem List/Core Data Sheet
_____ Medication List
_____ List of Allergies
_____ Immunization Record
_____ Most Recent History and Physical
_____ Most Recent Progress Note
_____ Consultation Reports

Other Physician/Hospital Records from:
_____ Laboratory Results Dated: _____ to _____
_____ X-Ray/Imaging Reports Dated _____ to_____
_____ Other _____

4. 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.

5. The information may be disclosed to or from the following individual or organization:

Front Royal Family Practice
140 W. 11th Street
Front Royal, VA 22630
Phone: 540-631-3700
Fax: 540-635-1673

For the purpose of: Continuity of Care/Coordination of Services

Are you transferring care? _____ If yes, Why: _____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke the authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that 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. Unless otherwise revoked, this 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 1 (one) year.

7. 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 ensure treatment. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

If I have questions about the disclosure of my health information, I can contact the practice privacy office.

Signature of Patient or Guardian: _____

Relationship to Patient _____ Date: _____

HEALTH HISTORY QUESTIONAIRE

Demographic Information

Patient Name (Last, First, M.I.):_____

Date of Birth:_____ Place of Birth:_____

Sex:_____ Marital Status_____

If married, spouse's name:_____

Pharmacy Name and Location: _____

Current Medications: Please list or attach a list of medications

Medication (Including vitamins and supplements Strength (e.g. 20 mgs) Dosage Schedule

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Allergies (Medications/Seasonal/Latex) Reaction

_____
_____
_____
_____
_____

Past Medical History

Previous Primary Care Physician Name: _____

Previous Primary Care Physician Phone Number: _____

Previous Primary Care Physician Address:_____

PLEASE SEE BACKSIDE OF FORM FOR ADDITIONAL QUESTIONS

Past Medical History (Cont'd)

Previous/Current Treatments Currently Receiving Treatment(Y/N) Condition Resolved(Y/N)
(**e.g. Acupuncture, Physical Therapy, Chiropractic, Psychiatry, etc**.)

_____
_____
_____
_____
_____

Procedures (Please include dental procedures and appliances) Month/Year

_____
_____
_____
_____

Pregnancy History

Live Births/Miscarriages Delivery Method (Vaginal/C-Section) Complications

_____
_____
_____
_____

Radiology Studies (MRI, CT Scans, X-rays) Month/Year

_____
_____
_____
_____

Injury History (e.g. vehicle/motorcycle, falls, sports injuries) Month/Year

_____
_____
_____
_____

Immunizations *(check if Yes and indicate year of last injection)*

___ Influenza	___ Pneumonia	___ MMR
___ Tetanus	___ Hepatitis A or B	___ Other

Screening/Prevention History (give year of last test if applicable)

Blood Sugar (Glucose): _____Ordering Provider: _____

Cholesterol: _____Ordering Provider: _____

Pap : _____ Ordering Provider: _____

Patient Name: _____ Date of Birth_____

Mammogram: _____ Ordering Provider: _____

Prostate Exam: _____ Ordering Provider: _____

Colonoscopy: _____ Ordering Provider: _____

Bone Density: _____ Ordering Provider: _____

Eye Exam: _____Ordering Provider: _____

Family History

Has any blood relative ever had? (Check Yes for that apply and indicate relationship e.g. mom, dad)

___ Alzheimer's	___ Heart Attack	___ Alcoholism
___ Tuberculosis	___ Bleeding Disease	___ Mental Disorder
___ Diabetes	___ Stroke	___ Allergies
___ High Blood Pressure	___ Seizures	___ Asthma
___ Heart Disease	___ Depression/Suicide	___ Cancer

Social History

Tobacco Use:
Do you smoke? _____ If so, how many cigarettes/cigars per day? _____
Number of years smoking? _____ Do you chew tobacco_____ Have you thought about quitting? _____ Have you quit before?_____ How long?_____

Alcohol Use:
Do you drink alcohol? _____If, so what type(s)? _____
How many drinks do you have in 1 week? _____

Drug Use:
Any history of recreational (illegal, pain medication) drug use? _____
If so, what type(s)?_____
When? _____

Disease Exposure:
Have you been exposed or currently (circle all that apply): AIDS, HIV, Herpes, Syphillis, Tuberculosis, SARS, and/or Other(s)_____

Exercise/Nutrition:
Are you currently following a dietary lifestyle and/or regular exercise regimen? _____
How much caffeine do you consume on a daily basis?_____

Employment:
Are you currently employed? _____How many jobs are you currently working?_____
Occupation_____

Please use the additional line below to report any information you would like us to know.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

The information listed above is true to the best of my knowledge.

_____ _____

Signature Date