DeKalb Medical Physicians Group

PATIENT INFORMATION - PLEASE PRINT

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	APT#	CITY, STATE ZIP

HOME PHONE	CELL PHONE	PREFERRED PHONE	EMAIL ADDRESS

EMERGENCY CONTACT NAME	TELEPHONE NUMBER	RELATIONSHIP TO PATIENT

PRIMARY EMPLOYER	WORK PHONE

ADDRESS	CITY, STATE ZIP

RESPONSIBLE PARTY INFORMATION (If Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY /BILLING ADDRESS (If Applicable)

HOME PHONE	CELL PHONE	PREFERRED PHONE	CITY, STATE ZIP

EMPLOYER	RELATIONSHIP TO PATIENT

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		$	
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
		$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (If Applicable)

NAME OF INSURANCE COMPANY		POLICY#	
NAME OF INSURED		GROUP#	
ADDRESS OF INSURANCE COMPANY		COPAY AMT	
		$	
CITY, STATE ZIP	PHONE	DEDUCTIBLE	
		$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

I authorize the release of any medical or other information necessary to process this claim, including information related to AIDS, Mental Health, and Substance Abuse. I authorize payment of medical benefits to the physician or supplier for all services rendered. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

DeKalb Medical
Physicians Group

Patient Demographic Information

Name: _____ Date of Birth: __ / __ / ____ Date: __ / __ / ____

Please select only one answer in each of the categories below by placing a mark in the box provided.

Gender

- ☐ Male
- ☐ Female
- ☐ Undifferentiated

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race

Language(s)

Please indicate which language or languages you speak by placing a mark in the coresponding box.

- ☐ Arabic
- ☐ Bulgarian
- ☐ Portuguese
- ☐ Central Khmer
- ☐ Chinese
- ☐ Vietnamese
- ☐ English
- ☐ French
- ☐ German
- ☐ Haitian or Haitian Creole
- ☐ Hebrew
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Polish
- ☐ Russian
- ☐ Spanish

DeKalb Medical Physicians Group

Patient Medical History Form

Name: _____ Age: _____ Date of Birth: _____
Language(s) spoken:_____ Occupation:_____
Name of Primary Care physician: _____

1. What is the purpose of today's visit? _____

2. Please list all current medications: (including prescription, over the counter, vitamins, herbs, supplements, etc.)

Medication (name)	Dose (strength) mg, mcg	Frequency (How often you take med. Ex: 1 tab 2 times a day)	Medication (name)	Dose (strength) mg, mcg	Frequency (How often you take med Ex: 1 tab 2 times a day)

Please Circle preferred pharmacy:
Local pharmacy: _____ Phone Number _____
Address: _____
Mail Order Pharmacy: _____ Phone Number _____
Address: _____

3. Allergies: (Medications, X-ray Dyes, Other Substances):

Name of Medicine:	Type of Reaction:	Name of Medicine:	Type of Reaction:

4. Past Medical History:
Please check if you have had problems with or been diagnosed with any of the following:

___ Allergies
___ Anemia
___ Angina
___ Anxiety
___ Arthritis
___ Asthma
___ Atrial Fibrillation
___ Blood Clots/DVT/PE
___ Cancer:(Type) _____
_____
___ Cardiac Arrhythmia
___ COPD
___ Coronary Artery Disease
___ Depression
___ Diabetes/Sugar
___ Elevated Lipids/Cholesterol
___ GERD/Acid Reflux
___ Headache/Migraine
___ Heart Disease
___ Other: _____
___ Heart Valve Disease
___ Hepatitis/Liver Disease
___ High Blood Pressure
___ Irritable Bowel Syndrome
___ Myocardial Infarction/Heart attack
___ Osteoporosis
___ Renal/Kidney Disease or Stones
___ Seizure Disorder
___ Stroke/ TIA

5. Past Surgical/Hospitalization:
Please list any surgery or hospitalization which you have had and include the date(s):_____
_____
_____

6. List other Providers you see? **Provider _____ Reason _____**
Provider _____ Reason _____
Provider _____ Reason _____
Provider _____ Reason _____

7. Preventive Screening History:
Date of last physical? _____ Eye Exam?_____
Colonoscopy? _____ Prostate exam? ____ Mammogram? ____ Dexa Scan/ Bone Density? _____

8. Family History: *Please check and describe if any member of your family (including parents, siblings and grandparents) ever had:*

	Cancer (Type)	Heart Disease	Hypertension	Diabetes	Other
Mother					
Father					
Grandparents					
Brother(s)					
Sister(s)					

9. Safety/Social History:
Do you use tobacco? ___ Yes ___ No ___ Former Tobacco Type(s)?_____
Packs/Units per day?_____Number of years used? _____
Do you drink alcohol? ___ Yes ___ No ___ Former If yes, how many drinks per week? _____
Highest Level of Education Completed:_____ Marital Status_____
Do you have any children? ___ Yes ___ No ___# of sons ___# of daughters
What is your source of heat in your home? _____
Do you have a smoke detector? ___ Yes ___ No Do you have a carbon monoxide detector? ___Yes ___ No
Do you wear a seatbelt? ___ Yes ___ No Have you had any falls in the least year? ___Yes ___ No
Do you use drugs (including Marijuana, Cocaine, etc.)? ___ Yes ___ No
If yes, describe: _____
Do you wish to be tested for AIDS? ___ Yes ___No
Are you in a relationship in which you have been physically hurt? ___Yes ___ No
Do you ever feel afraid of your partner? ___ Yes ___ No
Is there a gun in your home? ___Yes ___ No
If yes, is it out of the reach of children, locked and unloaded? ___ Yes ___ No
Do you have a living will or Advanced Directive? ___Yes ___No

10. Immunization: *Have you received any of the following*:
Flu Date: _____ Shingles (Age 50 & over) Date: _____
Pneumonia Date(s): _____
Tetanus Date: _____ HPV (Age 12-26) Date: _____

11. Gynecologic/Obstetric History:
Age onset of menstrual period: _____ Length of Menstrual period: _____Frequency: _____
Number of Pregnancies: ____ Births ____ Full-term _____ Premature
____ C-Section ____ Miscarriages _____ Abortions
Age at first pregnancy: _____ Are you pregnant at this time? ___ Yes ___ No
Date of last Pap smear: _____ Have you ever had an abnormal pap smear?___Yes ___ No
If yes, please describe the finding and when:_____

12. Lifestyle: Are you on any special diet? ___Yes ___No If yes, what type? _____
Do you exercise? __Yes __No If yes, what type?_____ How often? _____

DeKalb Medical Physicians Group
DeKalb General Surgery & Surgical Oncology

Risk Assessment for Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal of father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer* (ER-, PR-, HER2-pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		POLYPOSIS SYNDROMES	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	10 or more cumulative (lifetime) colorectal adenomas (colon polyps)			

		MELANOMA	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Two or more melanomas in an individual or family			
Y	N	Melanoma and pancreatic cancer in an individual or family			
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

_____
Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing:
☐ HBOC ☐ Lynch ☐ Polyposis ☐ Melanoma
☐ Information given to patient to review
☐ Follow-up appointment scheduled Date: _____

☐ Patient offered genetic testing: ☐ Accepted ☐ Declined

_____
Healthcare Professional's Signature Date

*For a better understanding of triple negative breast cancer, please ask your healthcare provider.
Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines.

DeKalb Medical Physicians Group
DeKalb General Surgery & Surgical Oncology

Surgery Patient Health Assessment

Patient Name: _____ DOB: _____

Patient Review of Symptoms Checklist

Constitutional

Neg Pos
- ○ ○ Chills
- ○ ○ Fatigue
- ○ ○ Fever
- ○ ○ Malaise
- ○ ○ Night sweats
- ○ ○ Weight gain
- ○ ○ Weight loss
- ○ ○ Other

HEENT

Head\Eyes\Ears\Nose\Throat

Neg Pos
- ○ ○ Ear drainage
- ○ ○ Ear pain
- ○ ○ Eye discharge
- ○ ○ Eye Pain
- ○ ○ Hearing loss
- ○ ○ Nasal drainage
- ○ ○ Sinus pressure
- ○ ○ Sore throat
- ○ ○ Visual changes
- ○ ○ Other

Respiratory

Neg Pos
- ○ ○ Chronic cough
- ○ ○ Cough
- ○ ○ Know TB exposure
- ○ ○ Shortness of breath
- ○ ○ Wheezing
- ○ ○ Other

Cardiovascular

Neg Pos
- ○ ○ Chest pain
- ○ ○ Claudication
- ○ ○ Edema
- ○ ○ Palpitations
- ○ ○ Other

Gastrointestinal

Neg Pos
- ○ ○ Abdominal pain
- ○ ○ Blood in stools
- ○ ○ Change in stools
- ○ ○ Constipation
- ○ ○ Diarrhea
- ○ ○ Heartburn
- ○ ○ Loss of appetite
- ○ ○ Nausea
- ○ ○ Vomiting
- ○ ○ Other

Genitourinary

Neg Pos
- ○ ○ Dysuria
- ○ ○ Hematuria
- ○ ○ Polyruria
- ○ ○ Urinary frequency
- ○ ○ Urinary incontinence
- ○ ○ Urinary retention
- ○ ○ Other

Reproductive

Neg Pos
- ○ ○ Abnormal pap
- ○ ○ Dysmenorrhea
- ○ ○ Dyspareunia
- ○ ○ Hot Flashes
- ○ ○ Irregular menses
- ○ ○ Vaginal Discharge
- ○ ○ Other

Integumentary

Neg Pos
- ○ ○ Breast discharge
- ○ ○ Breast lump
- ○ ○ Brittle hair
- ○ ○ Brittle nails
- ○ ○ Hair loss
- ○ ○ Hirsutism
- ○ ○ Hives
- ○ ○ Pruritis
- ○ ○ Mole changes
- ○ ○ Rash
- ○ ○ Skin lesion
- ○ ○ Other

Neurological

Neg Pos
- ○ ○ Dizziness
- ○ ○ Extremity numbness
- ○ ○ Extremity weakness
- ○ ○ Gait disturbance
- ○ ○ Headache
- ○ ○ Memory loss
- ○ ○ Seizures
- ○ ○ Tremors
- ○ ○ Other

Psychiatric

Neg Pos
- ○ ○ Anxiety
- ○ ○ Depression
- ○ ○ Insomnia
- ○ ○ Other

Metabolic / Endocrine

Neg Pos
- ○ ○ Cold intolerance
- ○ ○ Heat intolerance
- ○ ○ Polydipsia
- ○ ○ Polyphagia
- ○ ○ Other

Musculoskeletal

Neg Pos
- ○ ○ Back pain
- ○ ○ Joint pain
- ○ ○ Joint swelling
- ○ ○ Muscle weakness
- ○ ○ Neck pain
- ○ ○ Other

Hematologic/Lymphatic

Neg Pos
- ○ ○ Easy bleeding
- ○ ○ Easy bruising
- ○ ○ Lymphadenopathy
- ○ ○ Other

Immunologic

Neg Pos
- ○ ○ Contact allergy
- ○ ○ Environmental allergies
- ○ ○ Food allergies
- ○ ○ Seasonal allergies

DeKalb Medical
Physicians Group

PATIENT CONSENT FORM

CONSENT FOR ROUTINE PROCEDURES & TREATMENTS

We are required by law to obtain a consent to treat and disclose "all material risks and alternative treatments." I understand that it is not possible to list every material risk for every Procedure or Treatment and that this form only attempts to identify the most common material risks and the alternatives associated with the Procedures or Treatments.

The Procedures may include, but are not limited to the following:

(1) **Needle Sticks**, such as injections (shots), intravenous lines, or intravenous injections. The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis of limb or death. Alternatives to needle sticks (if available) include oral, rectal, nasal, or topical medications (each of which may be less effective) or refusal of treatment.

(2) **Physical tests, assessments and treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks, and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures and/or refusal of treatment, no practical alternatives exist.

(3) **Administration of Medications** whether orally, rectally, topically or through the eye, ear or nose. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration and/or refusal of treatment, no practical alternatives exist.

(4) **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation and/or refusal of treatment, no practical alternatives exist.

By signing this form:

- I consent to Healthcare Professionals performing Procedures as they deem reasonably necessary in the exercise of their professional judgment, **including those Procedures that may be unforeseen or not known to be needed at the time this consent is obtained;** and
- I acknowledge that I have been informed in general terms of the nature and purpose of the Procedures; the material risks of the Procedures; and practical alternatives to the Procedures.
- **If I have any questions or concerns regarding these Treatments or Procedures, I will ask my physician to provide me with additional information**.
- In order to insure medication safety and lack of drug interactions, I grant DeKalb Medical and its staff the right to access my electronic pharmacy and prescription information.

Signature of Patient (or authorized person to sign): _____

Printed Name of Patient: _____

Reason Patient Unable to Sign (if applicable): _____

Date Signed: _____

[redacted]

Acknowledgement of Receipt of Notices of Privacy Practices (HIPAA): I acknowledge that I have received the notice of Privacy Practices.

_____ _____

Signature Date

Patient Approval Form for Physician Assistant: If this practice has a certified Mid-Level Provider available to treat patients for the level of care, which have been approved by the Georgia State Board of Medical Examiners, your signature on this form conveys that you are in agreement with being treated by a Mid-Level Provider, who is acting under the direct supervision of a physician.

_____

Patient Signature

Notice of Privacy Practices in the Use and Disclosure of Personal Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice applies to DeKalb Regional Health System (and all affiliates) and their medical staffs, employees and other health professionals who are approved to provide services at its facilities. Please note that physicians may have different privacy practices for services provided at their offices.

Understanding Your Health Record / Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and/or receive a copy your health record (a fee may be applied)
- obtain and/or receive a copy of your health record in electronic form if readily producible in such form (a fee may be applied)
- request an amendment or correction to your health record
- request that PHI be be provided directly to another individual
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

The organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- provide you notification in the event your information is breached.
- obtain your written authorization for any subsidized communications that market a health-related product or service.
- We will use or disclose your information consistent with 45 C.F.R. 164.514.4 (F) (i-vi). Such information shall be the minimum necessary to accomplish the desired purpose and may include: Demographic information relating to you including your name, address, other contact information, age, gender, and date of birth; Dates of health care provided to you; The department where you received services; Name of treating physician; Outcome information; and Health insurance status.
- provide you the opportunity to opt out of any fundraising communications

We are not required to agree to most restrictions you request on the use or disclosure of your information. However, we must agree to a restriction on disclosure of your information to a health plan for purposes of carrying out payment or health care operations if the information relates solely to a health care item or service for which you or your guarantor have paid us out of pocket in full. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose psychotherapy notes, use or disclose your information for marketing purposes, or use or disclose your information for purposes not described in this Notice without your written authorization.. DeKalb Regional Health System will not sell your information. A decedent's information is no longer protected under the HIPAA privacy law upon 50 years following death.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
Information obtained by, or treatment ordered or provided by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine your course of treatment.. . We will also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

We will use your health information for payment.
A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

- *Quality Improvement*: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in you health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
- *Business Associates*: There are some services provided in our organization through contacts with business associates. When these services are contracted, we may disclose your health information to our business associate **and applicable subcontractors** so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- *Directory*: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to people who ask for you by name.
- *Notification*: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care your location and general condition.
- *Communication with family*: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
- *Research*: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- *Funeral Directors*: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- *Organ procurement organizations*: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- *Marketing*: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- *Fund raising*: We may contact you as part of a fund-raising effort.
- *Food and Drug Administration (FDA)*: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- *Workers compensation*: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- *Public health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- *Correctional institution*: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
- *Law enforcement*: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

- *Federal oversight agency*: Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

For More Information or to report a Problem

If you have a question and would like additional information, you may contact the Privacy Officer at 404-501-5990. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. Please submit your question or complaint in writing and mail to: Privacy Officer, DeKalb Medical Center, 2701 North Decatur Road, Decatur, Georgia 30033

Effective Date: September 23, 2013

For More Information or to report a Problem

If you have a question and would like additional information, you may contact the Privacy Officer at 404-501-5990. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. Please submit your question or complaint in writing and mail to: Privacy Officer, DeKalb Medical Center, 2701 North Decatur Road, Decatur, Georgia 30033.
Effective Date: September 23, 2013

DeKalb Medical
Physicians Group

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (Print **patient's** full name)

_____ Birth date (Mo/Day/Yr)

_____ (Street address)

_____ Social Security Number

_____ (City, state, zip code)

_____ Phone (Home)

At the request of the individual, I _____, do hereby authorize _____
(Patient Name) (Practice Name)
_____to release:

_____Medical History
_____Progress Notes
_____Laboratory Reports
_____Radiology Reports
_____EKG Results
_____Other Ancillary Reports
_____Immunization Records
Other_____
_____

_____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: _____
Name of Company/Agency/Facility/Person

_____
Street address

_____
City, state, zip

PURPOSE OF DISCLOSURE:
_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL
OTHER (SPECIFY)_____

Please provide a DAYTIME telephone number in the event we need to contact you:_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 DAYS from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ **Signature of individual (or guardian or Personal Representative of patient's estate)**

_____ **Date**

MEDICAL INFORMATION RELEASED

Medical History_____ Radiology Reports_____ Immunization Records_____
Progress Notes_____ EKG Results_____ Other_____
Lab Reports_____ Other Ancillary Rpts____ _____

_____
ROI SPECIALIST

_____
DATE

A PHOTOCOPY OF THIS RELEASE IS VALID AS THE ORIGINAL.

DeKalb Medical Physicians Group

DeKalb Medical Physicians Group Patient Notice

HIPAA stands for the Health Insurance Portability and Accountability Act. This federal law has brought many changes to the healthcare industry, specifically in areas such as:

- Protecting and ensuring the privacy of patient's health information
- Regulation to protect electronic health information
- Standards for transmitting electronic data

As your provider, we are committed to maintaining the privacy of your healthcare information, as well as communicating with you in the most effective manner. Please take a moment to complete this form to ensure that we can contact you.

I authorize the DeKalb Medical Physicians Group to contact me regarding my medical information by means of the listed methods. I will also be responsible for contacting this office should this information change.

Home telephone #: _____
May we leave messages on your home answering machine? Yes No

Work telephone #: _____
May we leave messages on your work voice mail? Yes No

Cell phone #: _____
May we leave messages on your cell phone voice mail? Yes No

The providers/staff may use or disclose the following health information only to the following list of people:

- All test results Yes No
- The entire medical record Yes No
- Today's chart note Yes No
- Any healthcare provider or facility Yes No
- Spouse: Yes No Name: _____
- Parent(s): Yes No Name: _____
- Children: Yes No Name: _____
- Other: Please give name and relationship (aunt, uncle, cousin, parent, etc.)

Name:_____

_____

Patient/parent/guardian signature: _____

Dated signed: _____