Augusta Vascular Center

NEW PATIENT INFORMATION

Name:	**Date:**
Street Address: **City:** **State:** **Zip Code:**	**Email Address:**
Contact Numbers: **Cell:** **Home:**	**Date of Birth:** **Age:**
Social Security Number:	**Primary Care Physician:**
In Case of Emergency Contact Name: Relationship to you: Phone Number: Address:	**Diabetic:** YES NO **Are you allergic to (please circle one)** **IV Contrast:** YES NO **Latex:** YES NO **Dialysis Center:** _____ Days: _____ Shift: _____
Race: □ Caucasian □ African American □ Hispanic □ Other: _____	**Primary Language:** □ English □ Spanish □ German □ French □ Other: _____
Height _____ **Weight** _____	**Pharmacy of choice** Name: Phone: Address:
Have you had a pneumonia vaccination? Yes No If yes, when? _____ **Have you had a flu vaccination?** Yes No If yes, when? _____ **Have you had a mammogram?** Yes No If yes, when? _____	

***Please note that we use University Hospital for lab work.*

If your insurance requires you to use a different lab, it is your responsibility to let us know.**

According to the guidelines of the Federal Health Information Privacy Act, healthcare professionals, using their best judgment, may disclose to a family member/relative, close personal friend and/or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Please list those persons that you wish to receive information related to your care, including billing and appointment information: _____

_____

Also, please indicate whether any information may be left on voicemail or answering machine: YES NO

Patient Signature _____ **Date** _____

Augusta Vascular Center

I hereby authorize Augusta Vascular Center to disclose my individually identifiable protected health information (PHI) as described here to the person/organization named below.

Section A. Complete all sections:		
Patient Name:	Birth Date:	Social Security No.:
Patient Address:		
Name and Address of person(s) or organization(s) to whom this information will be sent:		

This authorization will expire on the following: (Fill in the Date or the Event but not both.) If I do not indicate a date, this will expire in one (1) year from the date of my signature below.

Date: _____ Event: _____

Purpose of disclosure:

Description of information to be released:
Medical record from (inset date) _____ to (insert date) _____
Check the appropriate boxes:

☐ Entire Record	☐ Medication Reports	☐ Other: _____
☐ History and Physical	☐ Radiology Reports	_____
☐ Operative Report	☐ Nursing Notes	_____
☐ Consultation Reports	☐ Physician Progress Notes	
☐ Laboratory Reports	☐ Physician Orders	

The following information will not be released unless you specifically authorize its disclosure by initialing the relevant lines(s) below:

_____ I specifically authorize the release of information pertaining to mental health treatment
_____ I specifically authorize the release of information pertaining to alcohol and/or drug abuse
_____ I specifically authorize the release of information pertaining to confidential HIV (AIDS) related information

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if not, I do, it will not have any affect on any action taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulation and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B. Signatures	
I have read the above and authorize the release of the protected health information as stated.	
Signature of Patient or Representative Authorized by Law*:	Date:
Print Name of Patient or Representative Authorized by Law:	Relationship to Patient:

Section C: Office use only. Complete all sections.

Received by: _____ Date from received: _____
Delivery method: ☐FAXED ☐ MAILED ☐ IN PERSON
Attending physician's signature authorizing release: _____ HR1004.b

- REPRESENTATIVE AUTHORIZED BY LAW MUST SUBMIT COPIES OF LEGAL DOCUMENT SUPPORTING HIS OR HER AUTHORITY TO ACT ON THE PATIENTS BEHALF