CAPE REGIONAL
PHYSICIANS ASSOCIATES

Patient Information

Patient Name: _____, _____, _____
Last First middle initial

Address: _____

Phones: _____, _____, _____
Home Work Cell

Sex: ___ Female ___ Male Date of Birth: ____ / ____ / ____
Mo. Day Year

E-Mail: _____ Primary Physician: _____

Marital Status: Single Married Widowed Divorced Separated

Emergency Contact: _____ Phone#: _____

Relationship: Father Mother Guardian Sibling Child Other

Address: ___ same, If different: _____

Insurance Information (Only if card is not provided):

Primary Insurance Company: _____ ID#: _____

Group#: _____ Co-Payment: _____

Additional Insurance: _____ ID# _____

Assignment of Benefits:
I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Cape Regional Physicians Associates for any medical services provided to me. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. I understand that it is my responsibility to notify the organization of any changes in my health care coverage. I understand that by signing this form I am accepting financial responsibility for all services received.

Privacy Notice Acknowledgement: By signing below, I acknowledge that I was provided access to Cape Regional's Notice of Privacy Practices.

Additional Information: (circle the applicable response)
Race: White, Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian
Ethnicity: Hispanic/Latino, Not Hispanic/Latino, Prefer not providing.
Primary Language: English, Spanish, Other: _____
Preferred Contact Number: Home, Work, Cell

Signature of patient or guardian Printed name of patient or guardian Date

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Authorization to Share Health Information

Patient Name (Please Print) _____ Date of Birth _____

By signing below you acknowledge (*please cross out, date and initial any section that you object to*):

1. **Confidential Communication:**

   Voicemail may be used to communicate Health Information with you.

   Text message, voicemail and/or email may be used to communicate information about your upcoming or past appointments.

2. **Sensitive Diagnoses:**

   Your health record may include information related to sexually transmitted disease, HIV/AIDS, behavior or mental health services, alcohol and drug information, genetic information and tuberculosis. By signing below you acknowledge we have permission to communicate the information to your Health Care Partner(s).

3. **Privacy Notice Acknowledgement:**

   I was provided access to Cape Regional's Notice of Privacy Practices.

Signature _____ Date _____

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Designation of Health Care Partners

Please provide the names of people with whom we may we share your Health Information:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Signature _____ Date _____

HealthCare Partner or Authorized Representative signature if patient is unable to sign: _____

Witnessed _____ Date _____

The authority for this release will expire one year from this signature date.

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Record Release Authorization

NOTE: Bolded Sections to be completed by Cape Regional as needed for continuity of care purposes.
Patient should only provide name and date of birth and sign / date form. Thank you!

Facility: _____ Fax#: _____

I hereby authorize you to release a copy of the medical records/information described below to:

Cape Regional Health System

Address: _____

Phone#: _____Fax#: _____

Requested Information: _____

Dates of Service: _____

Date of Request: _____

Patient Name: _____ Date of Birth: _____

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. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will remain in effect for a period of one year from the date stated below unless revoked.

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 re-disclosure and the information may not be protected by federal confidentiality and privacy regulations.

Signature of patient or guardian Printed name of patient or guardian Date