EmanateHealth™ Medical Group

Emanate Health Primary Care

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize _____ to disclose the following from the health record of:

Patient Name: _____ Date of Birth: _____

Address: _____ Medical Record #: _____

Phone: _____ Fax: _____

1. Purpose of Release Request

☐ Changing Providers ☐ Legal Reasons ☐ Doctor Consultation/Referral
☐ Personal Use ☐ Moving/relocating outside the area

2. Information to be disclosed: ☐ **Clinic visit(s)** ☐ **Hospital**

☐ Discharge Summary	☐ Emergency Record	☐ Most recent 2 year history
☐ History & Physical	☐ Laboratory Test(s)	☐ Progress Notes
☐ Operative Report	☐ Radiology Report(s)	☐ Complete Medical Record
☐ Consultation Reports	☐ Pathology Report(s)	☐ Immunization Records

☐ Other: _____

Please include information relating to *(initial if needed)*:

_____ HIV test results _____Substance abuse _____Mental Health _____Genetic testing

3. Please Choose One: ☐ Pick up ☐ Please mail ☐ Fax

4. I authorize the information designated above to be released **From**:	**5.** I authorize the information designated above to be released **To**:
Name of Facility: _____	Name of Facility: _____
Name of Doctor: _____	Name of Doctor: _____
Street Address: _____	Street Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax:

6. Duration: This authorization shall become effective immediately and shall remain in effect until _____ (enter date), or for one year from the signature date if no date entered.

Revocation: This authorization may be revoked in writing at any time prior to the release of information. Written revocation will not affect any action taken before receipt of the revocation.

Rediscloseure: I understand that FFPMG may not lawfully further use or disclose this health information unless another authorization is obtained from me, or unless disclose is specifically required or permitted by law.

7. _____ _____ _____

Signature of patient (or legally responsible person) State relationship to patient Date

EmanateHealth™ Medical Group

Primary Care Specialty Health History

Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision — Flashes
- ☐ Vision — Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Brest Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** to medications or substances
Pharmacy Name _____ Phone _____	

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓), if your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates: _____

SERIOUS ILLNESS/INJURIES

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

PREGNANCY HISTORY

		Complications if any

HEALTH HABITS

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____

Reviewed By: _____ Date: _____