Coastal Heart Institute
Charles Drake, MD
5354 Reynolds Street, Suite 303
Savannah, GA 31405
912-355-5333

Dear Patient,

We at Coastal Heart Institute wish to take a moment to welcome you to our Cardiology practice!

We want you to know that we appreciate the opportunity to take care of your healthcare needs, and we look forward to serving you. Your health is our primary concern. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. We offer a wide variety of clinical services to address your physical well-being.

In order to expedite the new patient registration process, we ask that you **complete** the enclosed patient information forms and bring the forms with you at the time of your appointment. Please **DO NOT** send them back in the mail. Completing this information ahead of time allows us to see you in a timely manner upon your arrival at our office, and ensures we have the information necessary to fully address your healthcare needs.

In addition, please bring the following items with you:

- A photo ID
- Your insurance card(s)
- Your copayment (if required by your plan)
- A list of any medications you are currently taking
- Any recent imaging on disk format or test results that pertain to your illness

Should you need to reschedule or cancel your appointment, please call us at least twenty-four hours in advance to allow us the courtesy of offering your spot to another patient. Our phone number is 912-355-5333.

Thank you for choosing Coastal Heart Institute for your healthcare needs!

Patient Information	**Primary Care Physician** **Referring Physician**
Last Name **First Name** **M**	**Nickname**

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Address	City	State	Zip Code
Phone (Home)	(Cell)	Birthdate(MM/DD/YYYY) Male ❑ Female ❑	
Marital Status Single ❑ Married ❑ Divorced ❑ Widowed ❑		Social Security Number	
Ethnicity Non-Hispanic or Non-Latino❑ Hispanic/Latino ❑		Race	Language ❑ English Other:___________

Guarantor Information

Last Name First Name M		Relationship to Patient	
Address	City	State	Zip Code
Phone (Home)	(Cell)	Birthdate(MM/DD/YYYY)	
Social Security Number		Employer	

Employer Information

Occupation		Employer	
Employer Address	City	State	Zip Code
Work Phone		Extension	

Insurance Information on Primary

Insurance Company Name	Effective Date of Coverage		Co-Payment Amount
Address	City	State	Zip Code
ID/Policy Number		Group Number/Name	
Subscriber/Insured Name		Relationship to Patient	
Social Security Number		Birth Date (MM/DD/YYY)	

Continued next page:

Insurance Information on Secondary

Insurance Company Name	Effective Date of Coverage		Co-Payment Amount
Address	City	State	Zip Code

COASTAL HEART INSTITUTE

ID/Policy Number	Group Number/Name
Subscriber/Insured Name	**Relationship to Patient**
Social Security Number	**Birth Date (MM/DD/YYY)**
Insurance Information on Secondary	

Emergency Contact

Name #1		Relationship to Patient
Home Phone	**Cell Phone**	**Work Phone**
Name #2		**Relationship to Patient**
Home Phone	**Cell Phone**	**Work Phone**

Assignment and Release

Authorization to treatment and release information to insurance carrier for direct payment to the provider. I authorize treatment and the release of any medical information (acquired in my treatment) to process claims to my insurance company. I authorize direct payment from my insurance company to my provider. At any time I decide that I want to file my own claims, understand that payment in full will be required at the time of service. I also understand that I will be financially responsible for all charges incurred.

Patient Signature ______________________________ Date ______________

Patient Medical History

Today's Date: ______________ Date of Last Physical Exam: ______________

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Last Name: «LastName»__________ First Name: «FirstName»__________ Middle: __________

Chief Complaint:
What is the main reason for your visit today? *(Describe your problem in detail)* ____________________

____

HISTORY OF PRESENT ILLNESS

Location of the problem:

____

How long does the problem last?

____

On a scale of 0-10, with 10 being the most painful, circle the number that best describes the problem.

0 1 2 3 4 5 6 7 8 9 10

Is anything else occurring at the same time?
Yes No If yes, please explain.

____
____

When did you first notice the problem?

____

Is the problem constant or variable?
Dull then sharp Very sharp then stops

Other ____________________

MEDICAL HISTORY

- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorder
- ❑ Seizure Disorder
- ❑ Cancer

Organ __________

- ❑ Diabetes
- ❑ Gall Bladder Disease
- ❑ Heart Disease/Heart Attack
- ❑ Stroke/Mini-stroke
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Thyroid Disease
- ❑ Lung Problems
- ❑ Migraines
- ❑ Neck/Back Problems
- ❑ Reflux/Heart Burn
- ❑ Tuberculosis
- ❑ Other____________________

PROCEDURE HISTORY

Surgery	Date (year)
❑ Heart Bypass/Valve Replacement	__________
❑ Hernia Repair	__________
❑ Gallbladder Removed	__________
❑ Joint Replacement	__________
❑ Bladder/Kidney Surgery	__________
	__________

Surgery	Date (year)
❑ Organ Transplant	__________
❑ Stomach Surgery	__________
❑ Appendix Removed	__________
❑ Back/Neck Surgery	__________
❑ Prostate Surgery	__________
❑ Tonsils Removed	__________
❑ Other__________	__________

Patient Printed Name: «FirstName» «LastName»____________________ Date ____________________

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FAMILY HISTORY

List all serious illnesses in your **immediate family**. *Examples include Seizures, Headaches, Tremors, Dementia, etc.*

Illness	**Relationship**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

SOCIAL HISTORY

***Tobacco Use*:**
- ❑ Every Day
- ❑ Some Days
- ❑ Former Smoker
- ❑ Never Smoked

Type:
- ❑ Cigarettes
- ❑ Cigars
- ❑ Smokeless
- ❑ Pipe
- ❑ Other ____________

Use Per Day __________________ Number of Years Used __________

If past use, age started __________ Stopped at What Age __________

Alcohol Use:
- ❑ Current Use
- ❑ Past Use
- ❑Never Used

Type:
- ❑ Beer
- ❑ Wine
- ❑ Liquor
- ❑ Other __________

Frequency:
❑ Daily ❑ 3-5 times/week ❑ 1-2 times/week ❑ 1-2 times/month ❑ 1-2 times/year

If past use, how long ago quit ____________

Illicit Drug Use:
- ❑ Current Use
- ❑ Past Use
- ❑ Never Used

Type:
- ❑ Amphetamines
- ❑ Cocaine
- ❑ Ecstasy
- ❑ Hallucinogens/LSD
- ❑ Heroin
- ❑ Inhalants/Glue
- ❑ Marijuana
- ❑ Methamphetamines
- ❑ Other _____________

Frequency:
❑ Daily ❑ 3-5 times/week ❑ 1-2 times/week ❑ 1-2 times/month ❑ 1-2 times/year

If past use, how long ago quit ____________

Allergies: Name	What kind of reaction do you have?
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Patient Printed Name: «FirstName» «LastName» ____________________ Date ______________

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MEDICATION LIST

Are you taking any medications? **Yes or No** ***(If yes, list all)***

	Name/Dosage	How often do you take this medicine?
1.	______________________	______________________
2.	______________________	______________________
3.	______________________	______________________
4.	______________________	______________________
5.	______________________	______________________
6.	______________________	______________________
7.	______________________	______________________
8.	______________________	______________________
9.	______________________	______________________
10.	______________________	______________________
11.	______________________	______________________
12.	______________________	______________________
13.	______________________	______________________
14.	______________________	______________________
15.	______________________	______________________

Patient Printed Name: «FirstName» «LastName»____________________ Date ___________________

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Patient Review of Systems

Do you now have any problems related to the following systems?

Circle Yes or No

Please explain any yes answers in the space to the right

Gastrointestinal

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Heartburn	Y	N
Burping	Y	N
Blood in stool	Y	N
Other ______________________		

Cardiovascular

ChestPain	Y	N
Shortness of Breath	Y	N
Varicoseveins	Y	N
Palpitations	Y	N
Swelling of extremities	Y	N
Other ______________________		

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Sweating	Y	N
Weight loss	Y	N
Weakness	Y	N
Other ______________________		

Skin

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Change in fingernails	Y	N
Hair loss	Y	N
Other ______________________		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Other ______________________		

Musculoskeletal

Joint pain	Y	N
Back pain	Y	N
Neck pain	Y	N
Other ______________________		

Ear / Nose / Throat

Ear pain	Y	N
Hard of hearing	Y	N
Sore throat	Y	N
Runny nose	Y	N
Other ______________________		

Hematologic / Lymphatic

Swollen glands	Y	N
Easy bruising	Y	N
Other ______________________		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Memory problems	Y	N
Frequent headaches	Y	N
Other ______________________		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Sputum	Y	N
Other ______________________		

Endocrine

Excessive Thirst	Y	N
Fatigue	Y	N
Other ______________________		

Allergic / Immunologic

Seasonal allergies	Y	N
Sneezing	Y	N
Watery/Itchy	Y	N
Other ______________________		

Female Genitourinary

Frequent urination	Y	N
Urgent urination	Y	N
Pain on urination	Y	N
Vaginal discharge	Y	N
Urine leakage	Y	N
Lower abdominal pain	Y	N
Blood in urine	Y	N
Painful menstruation	Y	N
Other ______________________		

Male Genitourinary

Pain in the testicles	Y	N
Penile discharge	Y	N
Blood in urine	Y	N
Night time urination	Y	N
Frequent urination	Y	N
Dribbling of urine	Y	N
Difficulty starting urine	Y	N
Other ______________________		

Patient Printed Name: «FirstName» «LastName» ____________________ Date ________________

COASTAL HEART INSTITUTE

Insurance Preferred Services

Many insurance companies are now specifying which commercial laboratories, hospitals, radiology services and other services you may use for studies. It is your responsibility as the patient to be aware of this information.

Our in-office lab can perform only limited testing in all cases, and when appropriate, we will perform what we can in-house. All other specimens must be sent to a reference lab. Laboratory testing will be sent to St. Joseph's/Candler Health System laboratory unless you indicate otherwise.

Please indicate below your insurance carrier's preferred lab and/or radiology services. Inaccurate or erroneous information will result in your being held responsible for all lab charges.

****VERY IMPORTANT****
If you do not designate a preferred laboratory, your test will be sent to our preferred facility St. Joseph's/Candler. If your insurance does not cover this facility you will be responsible for payment.

Laboratory

St. Joseph's/Candler ___________

Other (please provide name) ____

Radiology

St. Joseph's/Candler ___________

Other (please provide name) ____

By signing this document, I hereby acknowledge that I understand and agree to its content.

Patient Printed Name: «FirstName» «LastName»________________________

Patient Signature ____ Date ______________________

COASTAL HEART INSTITUTE

Joint Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The following organizations use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive through healthcare operations. The Organizations who are covered under this Notice include St. Joseph's/Candler Medical Group.

How We May Use or Disclose Your Health Information

For Treatment. We will use your protected health information to provide, coordinate, or manage your medical treatment and services. For example, we may disclose protected health information to another physician or health care provider who becomes involved in your care. This information is necessary for health care providers to determine what treatment you should receive.

For Payment. We will use protected health information for purposes of obtaining payment for treatment and services that you receive. For example, a bill may be sent to you or a third party, such as an insurance company. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to evaluate the performance of our staff; assess the quality of care; learn how to improve our facilities and services. This includes sending information to a third-party to conduct research on patient satisfaction and effectiveness of the services performed.
We may use or disclose your information to provide appointment reminders. We may call you by name in the waiting room when the provider is ready to see you.
We may use or disclose your protected health information to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Required by law. We may use and disclose information about you as required by law. For example, for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed to a public health authority who is permitted by law to collect or receive this information. The disclosure may be necessary to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by law. We may use and disclose information about you as required by law. For example, for judicial and administrative proceedings pursuant to legal authority; to report information related to victims of abuse, neglect or domestic violence; and to assist law enforcement officials in their law enforcement duties

Funeral Directors/Coroners. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Workers Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent Coastal Heart institute and this physician's office has taken action in reliance on such.

<u>Your Rights to Privacy</u>

You have the right to request a restriction on certain uses and disclosures or your information. However, the organizations listed above are not required to agree to a requested restriction.
You have the right to obtain a paper copy of the Notice of Privacy Practices upon request to the Privacy Official or a member of the organization.

You have the right to inspect and obtain a copy of your health record as allowed by state and federal regulations.

You may request an amendment to your health record as allowed by state and federal regulations.

You may also request communications of your health information by alternative means or at alternative locations. For example, by sending information to a P.O. Box instead of your home address.

You may revoke your Authorization to use or disclose health information except to the extent that action has already been taken by providing written notice to the Medical Record Department, Coastal Heart Institute, at this office site address.

You may receive an accounting of disclosures made of your health information as provided by federal regulations by sending a written request to the Medical Record Department at the address listed above. Your request must state a time period which may be no longer than six years and may not include dates before April 14, 2003.

If you have a concern or complaint about your privacy rights:
Contact the Privacy Official at
5353 Reynolds Street, Savannah, Georgia 31405.
You may also contact the Department of Health and Human Services, if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Our Obligations Under This Joint Notice

We are required by law to maintain the privacy of protected health information and to provide you with a Notice of our legal duties and privacy practices with respect to the protected health information. We will accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations. For reasons other than those stated above or as allowed by law, we will obtain your written authorization to use or disclose your health information. We will notify you if we are unable to agree to a requested restriction on how your information is used or disclosed. We are also required to comply with the terms of the Notice currently in effect.

We reserve the right to change our information practices and to make the new provisions effective for all protected health information we maintain. The revised notice will be made available to you by requesting a copy of an updated Notice. You may send a written request to the Privacy Official at 5353 Reynolds Street, Savannah, Georgia 31405.

You may also view this notice on your website, www.sjchs.org.

This Notice of Privacy Rights is effective on
April 14, 2003.

By signing this document, I hereby acknowledge that I have received a copy of the St. Joseph's / Candler Health System, Inc. Joint Notice of Privacy Rights.

____
Patient Signature

«FirstName» «LastName»________________
Patient Printed Name

____
Guardian Signature: (if applicable)

____
Relationship to the Patient

Date: _____________________________

OR:

Reason Acknowledgement was not obtained:
____
____
____

____
Witness

____
Witness

Date______________________

AUTHORIZATION FOR RELEASE OF INFORMATION

FOR SPECIFIC PURPOSES (HIPAA DISCLOSURE FORM)

I hereby authorize Dr. Charles Drake to release the following information from the health records of:

Patient Name: «FirstName» «LastName»_____________ **SSN:** ________________________ **DOB:** _______________

To be released to:

Name: ______________________________ Relationship:___________________ DOB: ______________ Phone: _______________

Name: ______________________________ Relationship:___________________ DOB: ______________ Phone: _______________

Name: ______________________________ Relationship:___________________ DOB: ______________ Phone: _______________

INFORMATION TO BE RELEASED: **(Check All That Apply)**

☐ Entire Record ☐ Lab Results ☐ Nursing Notes ☐ Demographics
☐Emerg. Room Notes ☐ Radiological Results ☐ Physician Orders ☐ Medication Records
☐ Dictated Reports (H&P, Discharge Summary, OP Note, Consults, Test Results, etc…)

FOR THE PURPOSE OF:

☐ Anything on behalf of patient

☐ Creating/Changing/Canceling appointments

☐ View or correct demographic information to include signing in on my behalf

☐ Receive documents containing my PHI on my behalf with an authorization for release of information signed by me.

☐ Picking up prescriptions/forms and or medications on my behalf.

☐Speaking to SJ/C Medical Group staff regarding my PHI including but not limited to billing and insurance information on my behalf.

☐ Other: ____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Medical Group at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The physician's office listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be re disclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **one year** from the date listed below.

Patient Signature ____ **Date** ________________________

Patient's Guardian or Capacity __________________________________ **Date** ________________________

Relationship to Patient ____

COASTAL HEART INSTITUTE

Financial Policy

We are dedicated to providing you with the best possible care and to maintain this relationship we find it necessary to implement the following financial policy. Your insurance company requires that you use in-network physicians, labs, hospitals and services in order to receive your maximum benefits. In effort to help you stay compliant with your insurance requirements:

- **Your insurance cards and picture id will need to be presented each time you visit our practice** to assure we have the most recent information. If insurance card is not provided, appointment will be handled as self-pay and payment for services will be collected prior to being seen.

- Co-payments must be paid **prior** to seeing the physician on the date service is rendered. Patients are responsible for their deductibles or charges not reimbursed by insurance. As a courtesy to you we file your insurance claims, therefore it is **your responsibility** to provide our office with up to date billing information.

- Please understand that your insurance is a contract between you and your insurance company and you are ultimately responsible for the bill. If you have not received an explanation of benefits **within 30 days** of seeing your physician you are expected to contact your insurance company for an explanation as to why payment has been delayed.

- Self-pay patients are required to pay for services prior to being seen for their visit and will be balance billed for the remainder of the fees at the time of charge posting.

- It is understood that returned checks made payable to this office for insufficient funds, stop payments or other reason for non-payment will be assessed a **$30.00 NSF fee** for which the patient will be held responsible.

- Patients with no financial ability to pay SJ/C's charges will be screened for eligibility under Medicaid and other state programs and/or evaluated against established guidelines for financial assistance. Please notify the Front Desk staff if you would like more information about how to apply for financial assistance.

- If you do not show up or if you do not cancel your follow up appointment within 24 hours of your scheduled appointment a **150.00 No Show fee** will be added to your account balance. This includes procedure appointments, new patient exams and office visits. (Effective September 1, 2014)

I have read and understand the financial policy of the practice and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice. I authorize the release of any medical information necessary to process my insurance claim.

____ _____________________________

Patient Signature or Responsible Party Date

COASTAL HEART INSTITUTE

Office Policies

Appointments, Cancellations and No-Shows

Appointments are generally scheduled Monday through Friday from 8:00am – 5:00pm. We believe that our patient's time is valuable. Every effort is made to keep your waiting time to a minimum. If you are unable to keep an appointment, please notify the office as soon as possible, preferably 24 hours prior to the appointment. This courtesy allows us to give appointments to another patient. **New patients must arrive 30 minutes prior to their first appointment in order to complete the necessary paperwork.** A 'no-show" is someone who misses an appointment without canceling within 24 hours of their scheduled appointment time. No-shows inconvenience those individuals who need access to medical care in a timely manner. Failure to present at the time of the schedule appointment will be recorded in the patient's record as a "no-show". **When three "no-show" appointments have been documented you will receive a letter from the physician discharging you from the practice**. We will offer 30 days of emergent care only and transfer your records when you find a new physician.

Co-payments , Deductibles and Non-Covered Services

Due to changes in today's healthcare, your insurance may not always pay for all services. You will be responsible for paying any claims that are not covered by your insurance. Your insurance plan requires us to collect a co-payment that will be requested at the time of service. For your convenience, we accept cash, check and most credit cards. If you have MEDICARE please familiarize yourself with the items and services for which Medicare will not pay.
Medicare does NOT pay for all of your health care costs. **When you receive an item or service that is NOT a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.** (If you have questions please ask for the NEMB form-Notice of Exclusions from Medicare Benefits.

Prescription Refills and Samples

You must contact your pharmacy directly for more expedient prescription refills. Please allow your pharmacy **up to 48 hours** to process your refill request. The pharmacist may need to check with your physician. Please do not call the nurse and leave multiple messages about your refill as this will only delay the process of completing your refill request. Please note that prescriptions will not be refilled after hours, on weekends or holidays. Some prescriptions cannot be refilled if you have not seen your physician within the last 6 months. When you are being seen by your physician, please remind him/her to refill your medications at the time of your visit. If you have mail away prescriptions, please allow 7-10 business days for the necessary forms to be completed. It is very important you plan ahead with mail away prescriptions to allow us adequate time to get all the paperwork completed.
As of January 1st 2009, we will no longer be able to provide medication samples on a phone call request or walk in basis due to concerns over patient safety. Recent confusion over medication instructions has put patients at risk. Samples may, if available, be provided during patient visits and when beginning new medications.

Laboratory and Test Results

Most laboratory tests can be performed in our in-house lab, but some special tests may be sent out. You must have an appointment for laboratory test and a lab order from your physician. If you think you need laboratory tests performed, but you don't have a lab order, please call your doctor's nurse. Your doctor must review all laboratory/tests results before they are released to the patient and filed in chart. Ordinarily you will be notified of normal results by mail or phone within 7-10 days. Your doctor will report abnormal results or reports on special procedures or biopsies as soon as they are available. If you have not heard from us within 7-10 days, please call our office.

Referrals and Prior-Authorizations

Most managed care plans require a patient be seen by their doctor prior to seeing a specialist. Referral and prior-authorization requests are handled here in the office. Please allow at least 7-10 business days for non-urgent requests. You will be notified when the request has been approved and the appointment has been made. Referrals will not be handled after-hours or on weekends.

Medical Records

Please note that requests for any health information cannot be processed without a signed Medical Record Release from the patient or legal representative. **A fee may be charged for this service.** This service is outsourced and processed weekly. Please allow up to 10-14 business days for your request to be processed.

Patient Signature ____ Date________________________

Coastal Heart Institute

Patient Contact Form

In order to ensure we are able to respond to you in a timely manner when you contact us, please provide the following:

Preferred
Phone Number: ____

Cell Phone Number: ____

Email address: ____

If you would like to receive reminders and/or confirmation regarding appointments, prescription refills or other information, please note your preferred method of communication. You may choose more than one.

❑ Voice Messages (*Please note preferred time to call)*

❑ *Morning* ❑ *Afternoon* ❑ *Evening*

❑ Text Messages (*Cell phone number required above*)

❑ Email (*Email address required above*)

Patient Printed Name: «FirstName» «LastName»_____________________

Patient Signature ____ Date ______________________

Standard text messaging rates may apply

AUTHORIZATION FOR RELEASE OF INFORMATION

Charles Drake MD
5354 Reynolds Street, Suite 303
Savannah, GA 31405
P: 912-355-5333 F: 912-355-5315

I hereby authorize **Dr. Charles Drake** to release / receive the following information from the health records:

Name: «FirstName» «LastName»______ **Date of Birth:** «DOB»__________

Social Security Number: «SSN»__________

☐ **Obtain From**	☐ **Release To**
______________________________ **Name of Entity or Physician**	______________________________ **Name of Entity or Physician**
______________________________ **Address**	______________________________ **Address**
______________________________ **City, ST Zip**	______________________________ **City, ST Zip**
______________________________ **Phone or Fax Number**	______________________________ **Phone or Fax Number**

Information to be released: *(Check All That Apply)*

☐ **Entire Record** ☐ **Lab Results** ☐ **Nursing Notes** ☐ **Demographics**

☐ **Emergency Room Notes** ☐ **Radiological Results** ☐ **Other** __________ ☐ **Physician Orders**

☐ **Dictated Reports (H&P, Discharge Summary, OP Note, Consults, Test Results, etc.)**

☐ **Medication Administration Record**

For dates of services rendered __________________________ **through** __________________

For the purpose of: ____

I understand that I can revoke this authorization by providing written notice to the Health Information Department of St. Joseph's/Candler Medical Group at the address listed above or in a manner described in the Notice of Privacy Rights. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid.

I PLACE NO LIMITATIONS ON HISTORY OF ILLNESS OR DIAGNOSTIC AND THERAPEUTIC INFORMATION, INCLUDING ANY TREATMENT FOR ALCOHOL, DRUG ABUSE OR DEPENDENCY, PSYCHIATRIC OR PSYCHOLOGICAL ILLNESS, MENTAL ILLNESS OR RETARDATION AND ACQUIRED IMMUNE DEFICIENCY (AIDS) SYNDROME.

The Entity listed above may not condition treatment, payment, on the signing of this authorization, unless allowed by law.

I understand that I am waiving my rights to privacy by releasing my medical information to the parties listed above and this information may be redisclosed by the receiving party. I hereby authorize the entity listed above to release the said information described above.

I understand that this Release of Information will expire within **ninety (90) days** from the date listed below.

Patient Signature ______________________________________ Date ____________________

Patient's Guardian or Capacity ____________________________ Date ____________________

Relationship to Patient __________________________________

For Health Information Management Department Use Only:

Request taken by: ______________________________________ Date completed: ____________________
Method of Release: ☐ Mail ☐ Pick Up ☐ Fax