AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please select location(s): ☐ **AGH** (Atlantic General Hospital) ☐ **AGHS** (Atlantic General Health System)
☐ **AHC** (Atlantic Health Center) ☐ **OTHER** (Specify) _____

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY #: (optional): _____ **CONTACT NUMBER:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

For this authorization my "Health Information" is: (charges may apply)

___ Complete Record (ALL)
___ Include information from other providers/facilities
___ Admission History & Physical
___ Discharge Summary
___ Outpatient Record
___ Emergency Room Record
___ Diagnostic Test/Results Reports (lab, x-rays and other test results)
___ Digital Images (CD)
___ Operative Report
___ Abstract Record (Discharge, Summary, History & Physical, Operative Notes and test Results)
___ Pathology Report
___ Other: _____

****Please initial below if release is to include:**

___ Drug & Alcohol Records
___ Mental Health Records
___ Other: _____

**** Date of Service Requested:** _____ **TO** _____

I authorize to disclose/release my Health Information by: ☐ Mail ☐ Email ☐ Pick up ☐ Fax (Dr. to Dr. only)

▶ **From Releasing Person or Entity:** _____	▶ **To Receiving Person or Entity:** _____
ADDRESS: _____	ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____	CITY: _____ STATE: _____ ZIP: _____
PHONE: _____	PHONE: _____
FAX: _____	FAX: _____
EMAIL: _____	EMAIL: _____

For the purpose of: _____

I understand there may be a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines. By signing this authorization, I agree to pay these fees at the time this request is made. This authorization is valid for one year from the date signed, unless I revoke this authorization. Atlantic General Hospital/Health System may contact me to extend this authorization, but I do not have to do so. Atlantic General will ask me for photo identification upon my request for my medical records. Atlantic General Hospital/Health System's medical staff and associates are pledge to maintain strict patient confidentiality in keeping with high ethical standards and in accordance with state and federal law. Atlantic General Hospital/Health System has procedures in place support this policy. These procedures make it very unlikely that my health information will be improperly re-disclosed. However, if this happens, my health information may no longer be covered by these privacy protections. I am not required to sign this authorization. Atlantic General Hospital/Health System does not condition treatment, payment, benefit eligibility or enrollment activities on the signing of this form. I may request a copy of this authorization upon signature. I may revoke this authorization at any time in writing by using the guidelines on the back of this form.

▶ **Patient Sign Here:** _____
Date/Time

I, _____ represent that I am the healthcare Agent/Guardian/Power of Attorney/Parent of the patient patient named above. (For Healthcare Agents, Guardians or Power of Attorney, *attach verifying documentation*.)

▶ **Personal Representative Sign Here:** _____
Date/Time

ADDRESS: _____ CITY/STATE/ZIP: _____ PHONE: _____

ATLANTIC GENERAL HOSPITAL
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

* S H A 0 0 5 *

By signing this authorization, I understand that medical records release may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc. I understand that release of psychotherapy notes requires an additional authorization.

Notice to the recipient of these records: If the information concerns a person treated for alcohol or drug abuse, the confidentiality of this information is protected by federal law (Federal Regulation 42 CFR part 2) and prohibits further disclosure of this information except with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient for this purpose.

To revoke this authorization, I must mail or fax my written request along with a copy of this original authorization to:

Atlantic General Hospital
ATTN: Medical Records
9733 Healthway Drive
Berlin, Maryland 21811
Phone: (410) 641-9614 or (410) 641-9616
Fax: (410) 641-3410

If I am unable to provide a copy of this original authorization with my request, I will provide the following information:

- Date of Authorization
- Name
- Address
- Phone Number
- Social Security Number
- Date of Birth
- Purpose of Authorization
- Description of Requested Health Information
- Person/Entity authorized to Use/Receive the Health Information.

If this original authorization was signed by my personal representative. the request to revoke will also include:

- My Personal Representative's Name
- Relationship
- Address
- Phone Number

I understand that if I am unable to provide all of the above information, Atlantic General Hospital may not be able to honor my revocation request I further understand that Atlantic General Hospital is unable to recall any of my Health Information that was released prior to my revocation of this authorization.

Authorization To Discuss Medical Information (HIPAA)

I _____ am authorizing _____
(Provider Name)

to discuss my medical information by: (please mark)

_____ Phone _____ During office Visit Only

To:

Name: _____

Relationship to patient: _____ Phone Number: _____

Name: _____

Relationship to patient: _____ Phone Number: _____

Name: _____

Relationship to patient: _____ Phone Number: _____

Please initial below on what information can be discussed:

_____ Abstract Medical Record (History & Physical, test result)

_____ Diagnostic Testing and/or Results (lab, pathology, x-ray, CT and other test results)

_____ Medications (any new medications, refill(s), requesting a change of medication)

_____ Immunization Record

_____ Emergency Room or Hospital

If there are any changes to whom my medical information can be discussed with, it will be my responsibility to inform the office.

Patient Signature: _____ Date of Birth: _____

Date signed: _____ Time signed: _____

Today's Date: _____

PATIENT

PATIENT INFORMATION

Legal First-Middle-Last Name:	Date of Birth:	Age:	Sex:
Preferred Name:			
Address:	City:	State:	Zip Code:
Preferred Contact Number:	Secondary Contact Number:	Email Address:	
Social Security Number:	Preferred Language:	Race:	
Marital Status: Single, Married, Divorced, Separated, Widowed, Undefined	How did you hear about us?:		
Emergency Contact Name:	Relationship:	Phone Number:	

INSURANCE

PRIMARY INSURANCE COVERAGE

Policy Holder Name:	Company Name:	
Date of Birth:	Social Security Number:	ID#:
Group#:	Insurance Address:	
Effective Date:	Employer Name:	
Employer's Phone Number:	Employer's Address:	

INSURANCE

SECONDARY INSURANCE COVERAGE

Policy Holder Name:	Company Name:	
Date of Birth:	Social Security Number:	ID#:
Group#:	Insurance Address:	
Effective Date:	Employer Name:	
Employer's Phone Number:	Employer's Address:	

RESPONSIBLE

PERSON RESPONSIBLE PARTY INFORMATION: SPOUSE, PARENT, OR GUARDIAN

First-Middle-Last Name:	Date of Birth:	Relationship:	
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Other:	

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PATIENT INFORMATION FORM

AGHS023

PATIENT HISTORY

Name:		**Today's Date:**
Address:		**Date of Birth:**
Home Phone:	**Cell Phone:**	**Work Phone:**
Primary Care Provider:		
Referring Provider:		
Race:	Caucasian, African American, Hispanic, Native Hawaiian, Asian, Pacific Islander, American Indian or Alaska Native, More than one Race, Refused to Report, Undefined	
Ethnic Background:		
Pharmacy: Local:		**Mail Order:**
Preferred Laboratory:	AGH, Lab Corp, Quest, Other:	
Do you have a living will:	☐ Yes ☐ No	

MEDICAL HISTORY / HOSPITALIZATIONS

List below any chronic illnesses and hospitalizations

1)	**7)**
2)	**8)**
3)	**9)**
4)	**10)**
5)	**11)**
6)	**12)**

PAST / PRESENT SURGICAL HISTORY

(Please Check any that apply)

Surgery	Type/Location	Date		Surgery	Type/Location	Date
☐ Brain				☐ Stomach		
☐ Neck				☐ Kidney		
☐ Thyroid				☐ Rectal		
☐ Bowel				☐ Hysterectomy		
☐ Back				☐ Hernia		
☐ Ovarian				☐ Pace Maker		
☐ Stents				☐ Breast		
☐ Prostate				☐ Skin Grafts		
☐ Aneurysm				☐ Appendix		
☐ Gallbladder				☐ Joint Replacement		
☐ Other				☐ Joint Replacement		

SPECIALISTS PROVIDERS

Have you ever seen the following specialist(s):

Urologist:	☐ Yes ☐ No	Name:	Phone:
GYN:	☐ Yes ☐ No	Name:	Phone:
General Surgeon:	☐ Yes ☐ No	Name:	Phone:
Neurologist:	☐ Yes ☐ No	Name:	Phone:
Pulmonologist:	☐ Yes ☐ No	Name:	Phone:
Cardiologist:	☐ Yes ☐ No	Name:	Phone:

Patient Name: _____ **DOB:** _____ **Date:** _____ **Time:** _____

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NEW PATIENT PAPERWORK

* A G H S 0 2 0 *

FEMALE

Total Number of Pregnancies:	Number of Births:	Number of Living Children:
Number of Miscarriages:	Age of 1st Menstrual Period:	Last Menstrual Period:

Type of Birth Control Used: ☐ None ☐ Condom ☐ Contraceptive Injections ☐ IUD ☐ Oral Contraceptives ☐ Patch ☐ Ring ☐ Tubal Ligation ☐ Partner had vasectomy ☐ Not currently sexual active

Do you perform self-breast exams: ☐ Yes ☐ No

MALE

Do you perform testicular self-exams? ☐ Yes ☐ No

Do you have any problems with any of the following? Scrotum, testicles, infertility, impotence/sexual function

FAMILY HISTORY

(Please indicate who in your family has this problem ... i.e.)
M=Mother, F=Father, S=Sister, B=Brother,
MGM= Maternal Grandmother, MGF= Maternal Grandfather, PGM=Paternal Grandmother, PGF= Paternal Grandfather

Alcoholism	Kidney Stones
Alzheimer	Mental Illness
Arthritis	Migraines
Asthma	Multiple Sclerosis
Cancer	Osteoporosis
COPD	Psychiatric Disorder
Clotting	Parkinson's
Depression	Prostate Cancer
Diabetes	Strokes
Dementia	Sleep Apnea
Epilepsy/Seizures	Sickle Cell
Emphysema	Thyroid Disorder
Glaucoma	Tuberculosis
High Blood Pressure	Tremors
Kidney Cancer	Ulcer
Kidney Disease	Other:

SOCIAL HISTORY

General Information

Relationship Status:

☐ Single ☐ Committed Relationship ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Caregiver:

☐ Self ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Aunt ☐ Uncle ☐ Sister ☐ Brother
☐ Host Family ☐ Foster Family ☐ Legal Guardian ☐ Step Family ☐ Adopted ☐ _____

Employment Status:

☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Homemaker ☐ _____

Significant Exposure:

☐ No Significant Exposure ☐ Fumes ☐ Dust ☐ Solvents ☐ Airborne Particles ☐ Noise ☐ Secondhand Smoke
☐ Asbestos ☐ TB ☐ _____

Highest Grade of School Completed:

☐ Did not complete high school ☐ High school degree ☐ College degree ☐ Graduate Degree ☐ _____

Patient Name: _____ **DOB:** _____ **Date:** _____ **Time:** _____

SOCIAL HISTORY

Spoken Language Preferred:
☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German ☐ Italian ☐ Korean ☐ Russian
☐ Sign Language ☐ Vietnamese ☐ Arabic ☐ _____

Reading Language Preferred:
☐ English ☐ Spanish ☐ Chinese ☐ Filipino ☐ French ☐ German ☐ Italian ☐ Korean ☐ Russian
☐ Braille ☐ Vietnamese ☐ Arabic ☐ _____

Special Needs:
☐ Visually Impaired ☐ Hearing Impaired ☐ Low Literacy ☐ English as second language
☐ Memory deficit/ Cognitive ☐ Physically Disabled ☐ Speech Impaired ☐ _____

Lives with:
☐ Alone ☐ Spouse ☐ Significant Other ☐ Child(ren), Adult ☐ Child(ren), Dependent ☐ Domestic Partner ☐ Friend(s)
☐ Grandparent(s) ☐ Other Relative(s) Specify ☐ Parent(s) ☐ Siblings ☐ Foster Family ☐ _____

Exercise History

Lifestyle Lead: ☐ Active ☐ Moderate Active ☐ Sedentary

Exercises Regular: ☐ Yes ☐ No

Activity During the Day? ☐ Mostly Sitting ☐ On My feet most of the day ☐ Some of each ☐ _____

How many days a week do you exercise? _____

Please select type of activity: ☐ Walking ☐ Biking ☐ Swimming ☐ Other: _____

Please select how many minutes of exercise at a time: ☐ None ☐ 1-10 ☐ 11-15 ☐ 16-20 ☐ 21-30 ☐ More then 30

Have you ever had to limit your exercise in any way: ☐ Yes ☐ No

Do you have any problems (i.e. low blood sugar, leg pain, shortness of breath) When exercising: ☐ Yes ☐ No

Travel and Pet History

Travel History:
☐ None ☐ _____

Identify Pet:
☐ No Pets ☐ Dog ☐ Cat ☐ Bird ☐ Fish ☐ Farm Animal ☐ Horse ☐ Hamster/Gerbil ☐ Rabbit ☐ Reptile
☐ Rodents ☐ None ☐ _____

Pet History:
☐ None ☐ _____

Emerging Infection Screening

Risk Exposure for emerging infection:
☐ No residence in or travel to emerging infection affected area ☐ Resided in affected area but no know exposure
☐ Travel to affected area but no known exposure ☐ Blood or body fluid contact with emerging infection patient

Substance Use

Caffeine use: ☐ Caffeine use current ☐ Does not use caffeine

If use caffeine: Type: ☐ Coffee ☐ Tea ☐ Pop/Soda ☐ Energy Drink ☐ _____

Caffeine amount/Frequency: ☐ 1-2 cups/cans per day ☐ 3-4 cups/cans per day ☐ 5-6 cups/cans per day
☐ 7-9 cup/cans per day ☐ 10 or more cup/cans per day ☐ occasional use

Caffeine withdraw pattern: ☐ Anxiety ☐ Difficulty Concentrating ☐ Depression ☐ Drowsiness ☐ Headache
☐ Intense desire for caffeine ☐ Irritability ☐ Loss of energy ☐ Nausea

Patient Name: _____ **DOB:** _____ **Date:** _____ **Time:** _____

Alcohol use: ☐ Alcohol Current ☐ Alcohol Past ☐ Alcohol never used

If Current or Past: Type: ☐ Beer ☐ Wine ☐ Liquor

Alcohol use Duration: _____

Alcohol Amount: ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks

Alcohol Frequency: ☐ Monthly or less ☐ 2-4 times/Month ☐ 2-3 times/Week ☐ 4 or more times/Week ☐ Daily

Street Drug/Inhalant/Medication on use Status: ☐ Current ☐ Past ☐ Neveruse

If Current or Past: Type: ☐ Amphetamines ☐ Cocaine ☐ Depressants ☐ Ecstasy ☐ Hallucinogens ☐ Heroin
☐ Inhalants (Solvents, gases nitrites, aerosols) ☐ Marijuana ☐ Mescaline ☐ Methamphetamine ☐ Narcotic ☐ PCP
☐ Sedatives ☐ Steroids ☐ Stimulants

PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS

(Please list name and frequency)

Medication Name	Dose	Frequency

MEDICATION ALLERGIES, ENVIRONMENTAL ALLERGIES or SENSITIVITIES

☐ **No Drug Known Allergies** **(Please list any known allergies or reactions)**

Medication, Environmental or Sensitivity	Reaction
1)	
2)	
3)	
4)	
5)	

Any seasonal allergies? ☐ Yes ☐ No (if yes, explain):

IMMUNIZATIONS/VACCINES/PREVENTATIVE CARE

(Please indicate approximate last date given)

Pneumonia Vaccine (Pneumovax 23):	☐ Never	Cholesterol Testing:	☐ Never
Pneumonia Vaccine (Prevnar 13):	☐ Never	Rectal Exam:	☐ Never
Flu Vaccine:	☐ Never	Prostate Blood Test:	☐ Never
Hepatitis B Vaccine:	☐ Never	Colonoscopy:	☐ Never
Shingles Vaccine (Zoster):	☐ Never	Pap Smear:	☐ Never
Shingles Vaccine (Shingrix):	☐ Never	Mammogram:	☐ Never
HIV or STD Testing:	☐ Never	Eye exam:	☐ Never
Tetanus Booster:	☐ Never	Foot exam:	☐ Never
Tdap:	☐ Never	Chest X-ray:	☐ Never
Pulmonary Function Test:	☐ Never	6 Min walk	☐ Never
Bone Density:	☐ Never	Gardasil:	☐ Never

Patient Name: _____ **DOB:** _____ **Date:** _____ **Time:** _____

Provider Signature: _____ **Date:** _____ **Time:** _____