



# Family Health Care Center

23702 U.S. Highway 80 East  
Statesboro, Georgia 30461  
(912) 489-4090  
Fax (912) 764-5028  
www.familyhealthcarecenter.com

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## CHILD NEW PATIENT REGISTRATION

Please complete & sign this form in its entirety before the end of your first appointment. It is important that all information completed be accurate and up to date. Please use your legal first and last name. Return to the front desk when complete.

### PATIENT INFORMATION:

Patient Name: \_\_\_\_\_  
*Last* *First* *MI*

Race: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

Hispanic, Latino, Spanish: Y / N Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_

Zip: \_\_\_\_\_

Primary Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell / Home Secondary Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

### PARENT/LEGAL GUARDIAN INFORMATION:

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian DOB: \_\_\_/\_\_\_/\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

#### In Case of EMERGENCY:

Please list the name of local friend or relative (not living at same address):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

\_\_\_\_\_



### Known Medication Allergies

MEDICATION	REACTION

### Surgical History

Type/Location	Doctor	Date

### Hospitalizations

Hospital/Date	Reason

### Social History (Please Check)

Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No		What kind? <input type="checkbox"/> Cigarette <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Vaping <input type="checkbox"/> Snuff	
How much do you use daily?	How long? (Years/Months)	Interested in quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you consume alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	How often? <input type="checkbox"/> Seldom <input type="checkbox"/> Socially <input type="checkbox"/> Daily	What kind?	
Mother: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Cause of Death:		
Father: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased	Cause of Death:		
Siblings: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Brothers:	Number of Sisters:	
Children: <input type="checkbox"/> Yes <input type="checkbox"/> No	How many?		
Do you see a Specialist?    Yes    No	Providers Name and Specialty:		



# Family Health Care Center

23702 U.S. Highway 80 East  
Statesboro, Georgia 30461  
(912) 489-4090  
Fax (912) 764-5028  
www.familyhealthcarecenter.com

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## OBGYN History (If Applies)

Please print your current OBGYN: \_\_\_\_\_ Phone: \_\_\_\_\_

### MENSTRUAL HISTORY (complete even if post-menopausal or no longer having periods)

1. Age at first period: \_\_\_\_\_ years.
2. Are your periods regular or irregular? \_\_\_\_\_
3. If your menstrual periods are regular; periods start every: \_\_\_\_\_ days
4. Average duration of bleeding: \_\_\_\_\_ days
5. Does bleeding or spotting occur between periods?  Yes  No
6. Does bleeding or spotting occur after intercourse?  Yes  No
7. First day of last menstrual period \_\_\_\_\_
8. Is pain associated with periods?  Yes  No  Occasionally
9. If yes to previous question, is it: before menses? \_\_\_\_\_ during menses? \_\_\_\_\_ both? \_\_\_\_\_
10. Do you use birth control?  Yes  No If yes, what form (pill, implant, IUD)? \_\_\_\_\_

Number of Pregnancies: \_\_\_\_\_

Number of Live Births: \_\_\_\_\_

Have you ever had a miscarriage, abortion, or still birth? If yes, please list with year: \_\_\_\_\_

---

---

## TO BE FILLED OUT BY PARENT OR GUARDIAN

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Does the child attend Day Care or After School Care? (please circle) YES NO

If Yes, Phone Number \_\_\_\_\_

### **PREGNANCY AND BIRTH**

Mother's Age at birth \_\_\_\_\_

Did mother have any illness during pregnancy?

NO YES

Did she take any medicines except vitamins/iron?

NO YES

Was the baby on time? NO YES

What was the birth weight and length?

\_\_\_\_\_ lbs. \_\_\_\_\_ in

Did he/she have any trouble starting to breathe?

NO YES

What type of delivery:

C-Section / Vaginal / Forceps / Vacuum

Any other problems in the hospital (jaundice, etc.)? NO YES

### **REVIEW OF SYSTEMS**

1. Has your child had frequent ear infections? NO YES

2. Any Eye Problems? NO YES

3. Any problems with teeth? NO YES

4. Does he/she have frequent colds? NO YES

5. Is there asthma, pneumonia, or recurrent cough? NO YES

6. Is there a heart murmur or heart problems? NO YES

7. Any problems with urination? NO YES

8. Ever had a UTI or Urinary Tract Infection? NO YES

If yes, what kind

\_\_\_\_\_

9. Any constipation or diarrhea? NO YES

10. Any convulsions or nervous system problems? NO YES

11. Any eczema, hives, or other skin condition? NO YES

12. Any anemia? NO YES

13. Please list any other physical complaints

\_\_\_\_\_

**PAST MEDICAL HISTORY**

Where has your child gone for check-ups until now?  
\_\_\_\_\_

Date of last check-up?  
\_\_\_\_\_

Date of last dental check-up? \_\_\_\_\_

Any allergies to medicines, foods, insects? NO YES  
If yes, Which ones? \_\_\_\_\_

Any hospitalizations? NO YES

Any Surgeries? NO YES  
For what? \_\_\_\_\_

Any serious injuries (head, broken bones, wrecks?)  
NO YES  
If yes, in what way?  
\_\_\_\_\_

Any medications taken regularly? NO YES  
Which ones? \_\_\_\_\_

Do you have record of immunizations? NO YES

**DEVELOPMENT AND BEHAVIOR**

At what age did your child roll over? \_\_\_\_\_ Months

At what age did your child sit alone? \_\_\_\_\_ Months

Did he/she say any word by age one year? NO YES

Does the child seem advanced or behind others his/her  
age? NO YES

Does he/she have trouble sleeping? NO YES

What grade is he/she in? \_\_\_\_\_

Any trouble in school (behavioral or academic)?  
NO YES

**FEEDING AND NUTRITION**

Is his/her appetite usually good? NO YES

Was there severe colic or unusual feeding  
during the first 3 months? NO YES

Do any foods disagree with him/her? NO YES

For the first six months, was he/she breast/bottle fed?  
(Circle)

If still on formula, which one?  
\_\_\_\_\_

Does he/she take vitamins? NO YES

**Circle if he/she has had any of the following:**

Nail biting, thumb sucking, bed wetting, problems  
with toileting, bad temper, hyperactivity, nightmares,  
speech problems, others  
\_\_\_\_\_

<p><b><u>FAMILY HISTORY</u></b></p> <p>Are there any smokers in the family? NO YES</p> <p>Are the child's parents in good health? NO YES</p> <p>Circle any diseases this child's family has had: (include parents, brothers/sisters, grandparents, aunts/uncles, and cousins)</p> <p>anemia, asthma, allergies, diabetes, TB, AIDS, high blood pressure, heart trouble, mental illness, drug or alcohol problems, inherited illness, cancer</p> <p>Please explain any significant problems below:</p> <hr/>	<p><b><u>SAFETY ENVIRONMENT</u></b></p> <p>Do you live in a house, apartment, mobile home, other (circle)</p> <p>Any pets in the home? NO YES</p> <p>Does he/she take fluoride? NO YES</p> <p>Do you know the hottest temperature of the water heater? NO YES</p> <p>Is there a working smoke alarm on each floor? NO YES</p> <p>Does he/she always use a car seat/seat belt in the care? NO YES</p> <p>Are there any problems in the condition of your home? (peeling paint, insects, mice, no heat/air, etc.) NO YES</p> <p>Does he/she always wear a helmet when biking? NO YES</p> <p>Do you have well water or city water? <hr/></p>

List age, gender and general health of brothers and sisters:

---



---



---



---



---



---



---



# Family Health Care Center

23702 U.S. Highway 80 East  
Statesboro, Georgia 30461  
(912) 489-4090  
Fax (912) 764-5028  
www.familyhealthcarecenter.com

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## Minor Patient Care Policy

Thank you for choosing Family Health Care Center to provide healthcare to your minor. In order to remain compliant with HIPAA rules and regulations, Family Health Care Center has adopted the following policy regarding treatment of a minor:

All minor patients must be accompanied by a legal guardian/caretaker when coming to the office for treatment, unless the patient is coming in for reproductive health, or the office staff has received written authorization to treat the patient in the form of the Consent for Minor Patient to be Treated document. Any lab results/procedures regarding reproductive health of a minor are protected by law and may not be disclosed without express consent of the minor patient. Therefore, lab results will not be disclosed over the phone to anyone but the patient, unless consent to release the results have been documented in the patient’s chart by the treating provider. If consent has not been given to release results over the phone, then an office visit with the minor patient and guardian must be scheduled to discuss results with the treating provider. For the health of the patient, treatment for any reproductive diseases/conditions that may have been uncovered during testing/procedures may begin prior to the office visit to discuss results with legal guardian/caretaker.

### Consent for Minor Patient to be Treated

Family Health Care Center requires that a minor patient be seen and accompanied by a parent or legal adult guardian at the initial visit. If the parent or guardian would like the minor patient to be seen unaccompanied for any subsequent visits, we must have signature authorization. Please fill out the form in its entirety.

Minor Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Person giving consent for treatment:

Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Relationship to minor (check one):

- Parent
- Legal guardian
- Caretaker

### Authorization:

I give my consent to have \_\_\_\_\_ seen and treated by Family Health Care Center without my presence. I give Family Health Care Center the right to discuss and treat the above patient’s disease, not limited to any prescriptions and procedures deemed necessary by providers at Family Health Care Center. I give consent for treatment to begin on the date listed below and understand that I may revoke this consent by giving Family Health Care Center written notice.

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

\*\*this form has no expiration date unless given written notice to discontinue





# Family Health Care Center

23702 U.S. Highway 80 East  
Statesboro, Georgia 30461  
(912) 489-4090  
Fax (912) 764-5028  
www.familyhealthcarecenter.com

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## INSURANCE INFORMATION

### Primary Insurance:

Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_ Subscriber SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

### Secondary Insurance (if applicable):

Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Subscriber: \_\_\_\_\_ Subscriber SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

\_\_\_\_\_ Please Initial if you are opting to be a self-pay patient, meaning you will be responsible for any and all charges accrued at the time of service. Payment for self-pay patients is due at the beginning of every visit, any additional charges will be collected at check-out.

By signing I agree that the above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I, as the patient, am responsible for **any copays and/or balances** not covered or left by insurance. I also authorize Family Health Care Center or insurance company to release any information required to process my claims.

**Parent/Guardian Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_



# Family Health Care Center

23702 U.S. Highway 80 East  
Statesboro, Georgia 30461  
(912) 489-4090  
Fax (912) 764-5028  
www.familyhealthcarecenter.com

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## Patient Insurances Preferred Services

Many insurance companies are now specifying which commercial laboratories, hospitals, radiology services and other services you may use for tests & studies. It is **YOUR** responsibility as the patient to be aware of this information. For instance, if your lab work is sent to a non-preferred lab, you will be responsible for payment.

Our in-office lab can perform only limited testing ordered by our providers and when appropriate, we will perform what we can in-house. All other specimens must be sent to a reference lab such as LabCorp. This means any outside lab orders preformed at this facility will be billed through LabCorp NOT Family Health Care Center.

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

If you are unsure, please contact your insurance carrier by calling the customer service number listed on the back of your insurance card.

Please check your insurances preferred service:

**Laboratory:**

LabCorp  
 Quest Diagnostics  
 Other: \_\_\_\_\_

**Radiology Services:**

East Georgia Regional Medical Center  
 Other: \_\_\_\_\_  
\_\_\_\_\_

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

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_



Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

### **FHCC Insurance Disclaimer**

Please be aware that you are responsible for any charges that are not covered by your insurance. It is the patient’s responsibility to make sure that our office is in network and is participating with your insurance plan. It is also the patient’s responsibility to know if the insurance requires you to have a designated Primary Care Provider (PCP).

If you are not sure our office is participating with your plan, or if your insurance requires you to have a dedicated PCP, please call the customer service number located on the back of the insurance card to verify participation and to make necessary changes.

With insurance constantly changing and the implementation of the AFFORDABLE Care Act (Obamacare), there is no way our office can accommodate the phone calls required to make sure we are in network with every patient’s insurance plan and/or call to verify if they will deny your medical claim due to missed premium payments.

We will file your insurance; this does not mean in any way that our office is a participating provider for your health plan, or that your insurance will pay for your visit if your PCP listed is not one of our providers. Therefore, you may receive an additional bill for any balances that were unpaid by your insurance. Please note that if your insurance premiums are not paid, any medical claims during that period will be **denied or pending**.

**For patients with PCPs different than the providers in our office- it is the patient’s responsibility to change their PCP to the appropriate provider or to provide written documentation that a PCP is not required for the patient’s specific plan. If you are currently in a grace period at the time of your visit, you will be treated as a SELF-PAY patient.**

**For patients that have managed health care plans- You MUST provide proof of FULL premium payment at the time of visit. If payments are not made by the end of your premium grace period, you will be held responsible for any and all charges for treatment from your visit. Therefore, any patient that is currently in a grace period will be treated as a SELF PAY patient.**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

\*\*\*This form does not have an expiration date



Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## HIPAA ACKNOWLEDGEMENT & PATIENT CONSENT

I. CONSENT FOR TREATMENT: I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physician(s). I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any medical personnel or other person(s) be exposed or report an exposure to my blood or body fluids, my blood will be tested for blood borne infections including Hepatitis Band C as well as HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I do. I have the right not to have any photos or videos taken of me unless I agree to this, except as needed to treat me. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

II. NOTICE OF PRIVACY PRACTICES: Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change; if we change our notice, you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office. The Clinic provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

By signing this form, I acknowledge that I have been provided with FHCC’s Notice of Privacy Practices to review and have been informed that I may obtain a copy upon request.

- I understand FHCC has a legal responsibility to protect patient privacy. To do this, the practice strives to keep patient information confidential and to safeguard the privacy of all patient information.
- I understand the FHCC has the authority to use and disclose my private health information to carry out treatment, payment, and healthcare operations, and that my private health information will not be released to other activities unless I sign a release authorizing this disclosure.
- I understand that Family Health Care Center has the right to change its Notice of Privacy Practices. If so, FHCC will issue a revised Acknowledgement of Review/Receipt of Privacy Practices.

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. Please note that this does not allow these individuals to obtain copies of my medical records without a complete and valid authorization from me.

Patient Printed Name: \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## **Appointment Cancellation & No-Show Policy Acknowledgement**

1. Missed Appointments: we understand that there are times when you must miss your appointment due to unforeseen circumstances. However, when you do not call to cancel an appointment, you may be preventing another patient from receiving much needed treatment. This practice requires 24-hours advanced notice if you are unable to keep your scheduled appointment. If your appointment is not canceled at least 24 hours in advance, you will be charged a \$50 no-show fee.
2. Scheduled appointments: we understand that delays may happen on the day of your scheduled appointment. Because we make every effort to keep patients and providers on schedule, it is imperative that you arrive on time for your scheduled appointment (or 15-mins early to complete any paperwork). Arriving late to your scheduled appointment causes the providers and timely patients to be pushed behind. If you arrive 15 minutes or later than your scheduled appointment time, we reserve the right to reschedule your appointment.
3. Anyone who fails to comply with any part of our policy may be asked to reschedule so you will have time to comply with the policy. Those who repeatedly miss appointments, are noncompliant with a plan of care, or are abusive to our staff may be rescheduled or dismissed from our practice.
4. Family Health Care Center reserves the right to discharge a patient (at the providers discretion) once the patient has accumulated four or more no shows within an 18-month time period.
5. This policy remains in effect until superseded. You will be provided a copy of this policy upon request.

**If you fail to cancel or reschedule within 24 hours of your scheduled appointment, fail to show up for the appointment, or show up more than 15 minutes late for the appointment; you may be charged a \$50 no-show fee (this fee does not apply to Medicare or Medicaid patients). This fee is not covered by insurance, and you will be responsible for paying the fee prior to your next visit.**

Due to insurance contacts **ALL COPAYMENTS** are due at the time of your appointment. Copayments will be collected **PRIOR** to services being rendered. If you do not have your copay upon check-in, your appointment will be rescheduled. Family Health Care Center requires that any uninsured/self-pay patient bring a minimum of \$150 to their scheduled appointment.

**Account Balances: ACCOUNTS WITH BALANCES MUST MAKE A PAYMENT AT EACH APPOINTMENT.** Accounts with no payments within 90 days will be turned over to collections. **If your balance is greater than \$300, you must make payment arrangements with the office Accounts Specialist prior to your appointment being scheduled.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature



# Family Health Care Center

23702 U.S. Highway 80 East  
Statesboro, Georgia 30461  
(912) 489-4090  
Fax (912) 764-5028  
www.familyhealthcarecenter.com

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## HIPAA FORM

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Please list any family member or other persons / physicians to whom Family Health Care Center may release information concerning your medical records:

NAME \_\_\_\_\_ PH# \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ PH# \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ PH# \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

Please list the best number for all appointment reminder calls: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Please Note: Our automated text reminder will automatically text all enrolled patients with appointments prior to the scheduled appointment date. Please reply YES to confirm.**

2. May Family Health Care Center leave messages on your home answering machine or voicemail?  
Please Circle: YES or NO
3. Please indicate if you would like to create a patient portal account. With this account, you will be able to review your lab results, ask non-urgent medical questions, request medication, and schedule appointments.  
Would you like to enroll? Please Circle: YES NO Already Enrolled
4. If permissible, please provide an email address to create a patient portal account.  
EMAIL: \_\_\_\_\_

*This will form remain in effect until I give written notification to discontinue.*

Patient or Guardian Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

**Parent/Guardians of minors under age 18 have access to medical records, with the exception of any State Law protecting the privacy of information of minors.**



# Family Health Care Center

23702 U.S. Highway 80 East  
Statesboro, Georgia 30461  
(912) 489-4090  
Fax (912) 764-5028  
www.familyhealthcarecenter.com

Thad H. Riley, M.D. | Angela Davis, M.D. | Zach McGalliard, M.D. | Alex Weathersby, FNP-BC | Kelly Tillman, FNP-BC | Kellie Whitener, FNP-BC

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip Code \_\_\_\_\_

*I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I may refuse to sign this Authorization, which will not affect my ability to obtain treatment or payment of claims. I have the right to revoke this authorization by providing written notice to Family Health Care Center. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.*

<p><b>I AUTHORIZE:</b></p> <p>_____</p> <p>Name of Physician / Health Care Facility / Other</p> <p>_____</p> <p>Street Address</p> <p>_____</p> <p>City, State, Zip Code</p>	<p><b>TO RELEASE PROTECTED HEALTH INFORMATION TO:</b></p> <p>_____</p> <p>Name of Physician / Health Care Facility / Other</p> <p>_____</p> <p>Street Address</p> <p>_____</p> <p>City, State, Zip Code</p>
--	---

### HEALTH INFORMATION TO BE RELEASED:

All Medical Records  Immunization Records  Lab Reports  X-ray Reports  Billing Records

Other (describe) \_\_\_\_\_

**OR THE FOLLOWING DATE(S) OR TIME FRAME (MM/DD/YYYY):** From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_

Federal and state laws require special permission to release certain information. Please check if these records **SHOULD BE** released:

Mental Health  Alcohol and/or drug abuse  HIV/AIDS test results  Developmental disabilities

### PURPOSE OR NEED FOR DISCLOSURE: (Check Applicable Categories)

Further Medical Care  Patient's Request  Insurance/Eligibility Benefits  Disability Determination  Legal Investigation

Other (please describe) \_\_\_\_\_

**EXPIRATION:** This authorization will expire on \_\_\_/\_\_\_/\_\_\_\_\_. If I do not indicate a date, this will expire one (1) year from the date on my signature below. A photocopy of this authorization is as valid as the original.

I understand that this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to persons and/or organizations named in this form the protected health information described in this form.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this authorization is signed by a representative on behalf of the patient, complete the following:

Representative's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_