Holmes Family Care

2564 NW Edenbower BLVD Ste 126
Roseburg, OR 97471
Phone: (541) 672-7718 Fax: (541) 315-7125
Email: office@holmesfamilycare.com

Please note: we must maintain the most up to date and accurate information on our patients. In addition to the face sheet present to you at every visit, we will request that you review and update this form at least once a year.

Date: _____

Patient Information

First Name: _____ MI: _____ Last Name: _____

SS#: _____ DOB: _____ Sex: _____ Preferred Pronouns: _____

Address: _____ APT #: ___ City: _____ ST: ___ ZIP: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____ Would you like to be signed up for the portal? O Yes O No

Please check the boxes below:

Best Contact Method: O Home O Cell O Work O E-mail O Mail O Portal
By checking one of the boxes for best contact method, I agree to receiving correspondence from HFC.

Material Status: O Single O Married O Divorced O Widowed O Separated O Life Partner

Employment Status: O Full-time O Part-time O Unemployed O Student O Disable O Retired

Race: O White O African American O Asian O American Indian/Alaska Native O Native Hawaiian/Pacific Islander O Declined O Other: _____

Ethnicity: O Not Hispanic/Latino O Hispanic/Latino O Declined Preferred Language: O English O Spanish O Other: _____

Do you have any communication difficulties/special needs? O No O Hearing loss O Interpreter required O Reading difficulty O Sight impaired O Other: _____

Financially Responsible Party

O Same as patient information (if different, please complete section below):

First Name: _____ MI: _____ Last Name: _____

DOB: _____ Relationship: O Spouse O Parent O Guardian O Other: _____

Address: _____ APT #: ___ City: _____ ST: ___ ZIP: _____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____ Employer: _____

Emergency Notification

Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____

Name: _____ Relationship: _____

Phone: Home: _____ Cell: _____

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Contact Information

How would you like to be notified of normal/negative lab/imagining results? O Phone (voicemail okay) O Portal O Letter

How would you like to be reminded about appointments? O Text O Phone Call

Do we have permission to leave a detailed voicemail? O Yes O No

Insurance Information

Primary Insurance: _____

ID: _____ Group #: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Relationship: O Self O Spouse O Parent O Other: _____

SS#: _____ Employer: _____

Secondary Insurance: _____

ID: _____ Group #: _____

Policy Holder Name: _____ Policy Holder's DOB: _____

Relationship: O Self O Spouse O Parent O Other: _____

SS#: _____ Employer: _____

Medication Refill

Please contact your pharmacy for medication refills. The pharmacy will fax us a medication refill request. Refill authorization may require 48-72 hours. Please allow sufficient time for us to process your refill request.

Initials: _____

Primary pharmacy name: _____ City: _____

Secondary pharmacy name: _____ City: _____

How did you find out about our office: _____

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Medical History

Name: _____ DOB: _____

Medications

Medications:	Dose:	Times Per Day:

Personal Medical History

Disease/Condition	Current	Past	Comments:
Alcoholism/Drug Abuse			
Asthma			
Cancer type:			
Anxiety/Depression			
Diabetes			
COPD			
Heart Disease			
High Blood Pressure			
High Cholesterol			
Thyroid Disease/issues			
Mental illness			
Kidney Disease			
Other:			
Other:			
Other:			

Allergies

Allergy	Reaction

Which lab do you prefer to use? O Mercy O Quest

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Obstetric/Gynecological History

Age of first menstrual cycle: _____ Date of last menstrual cycle: _____

Menopause: O No O Yes. When: _____

Menses monthly? O Yes O No Frequency of Cycles: ____ days O regular O irregular

Are you on birth control? O No O Yes What method or type? _____

Pregnancies: Total ____ Full term ____ Premature____ Miscarriages___ Abortions____

Surgeries

Type (specify left/right):	**Date:**	**Location/Facility:**

Hospitalizations:

Reason:	**Date:**	**Location/Facility:**

Social History

Occupation: _____ Employer: _____

O Retired O Unemployed O Disabled Years of education or highest degree: _____

Marital Status: O Single O Partner O Married O Divorced O Widowed

Tobacco Use:

Do you smoke Cigarettes? O No O Yes (please answer the questions below):

Current: Pack/Day: _____ Number of years: _____ Are you thinking about quitting? O No O Yes

Past: Quit Date: _____ Packs/day: _____ Number of years: _____

Do you use Marijuana or recreational drugs? O Yes O No

Have you used needles to inject drugs? O Yes O No

Do you drink caffeine? O No O Yes. How many cups per day: _____

Are you sexually active? O No O Yes. With O Males O Females O Both

Do you exercise? O No O Yes. How many times per week? _____

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Do you see any specialty doctors? O No O Yes

Office: _____ Specialty: _____ Reason: _____

Office: _____ Specialty: _____ Reason: _____

Office: _____ Specialty: _____ Reason: _____

Office: _____ Specialty: _____ Reason: _____

Preventive Screenings

Females:

- Last Cervical Cancer Screening (Pap smear) date? _____
- Have you had abnormal results?
  - No
  - Yes: _____
- Last Mammogram? _____
- Last Colonoscopy or colon cancer screening date? _____
- Last Osteoporosis screening? _____
- History of STD (sexual transmitted disease): Please check the ones that apply.
  - None
  - Chlamydia. When: _____
  - Gonorrhea. When: _____
  - Syphilis. When: _____
  - Genital Herpes. When: _____
  - HIV/AIDS. When: _____
  - Other: _____ When: _____

Males:

- Last Colonoscopy of colon cancer screening date? _____
- Last Prostate Screen? _____
- Last Aortic Aneurism Screening? _____
- History of STD (sexual transmitted disease):
  - None
  - Chlamydia. When: _____
  - Gonorrhea. When: _____
  - Syphilis. When: _____
  - Genital herpes. When: _____
  - HIV/AIDS. When: _____
  - Other: _____ When: _____

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Family History:

Name:_____ DOB: _____

Family Members	Statues: (Alive or Deceased)	Year of Birth	Diabetes	Hypertension	Heart Disease	High Cholesterol	Cancer	Mental Illness
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Brother (s)								
Sister (s)								
Son (s)								
Daughter (s)								

Other: _____

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Review of Systems (how are you feeling): Check all that apply

Constitutional:
O Body aches
O Fatigue
O Chills/Sweats
O Fever
O Weight changes

Cardiology:
O Chest pain
O Dizziness
O Irregular Heartbeat
O Leg Edema
O Heart Palpations

Ophthalmology:
O Blurred Vision
O Eye Pain
O Eye Discharge
O Eye Redness

Muscular:
O Joint Pain
O Muscle Pain
O Swelling

Lymph:
O Swollen nodes/glands
O Frequent Infections

Psychology:
O Depression
O Anxiety

ENT:
O Change in voice
O Cough
O Nasal Congestion
O Dizziness
O Ear Pain
O Nosebleed
O Hearing Loss
O Sore Throat
O Snoring
O Sinus Pain

Gastroenterology:
O Abdominal Pain
O Change in appetite
O Change in bowel habits
O Constipation
O Diarrhea
O Nausea/Vomiting
O Heartburn/Indigestion
O Blood in stool
O Rectal Complaints

Neurological:
O Headache/migraine
O Dizziness
O Memory loss
O Seizures
O Sleep Disturbance
O Visual change
O Poor balance
O Numbness/Tingling

Dermatology:
O Ance
O Brusing
O Dry/Sensitive Skin
O Eczema
O Hives
O Rash
O Mole Change

Endocrinology:
O Excessive Thirst/Hunger
O Weight Gain/Loss
O Cold/Heat Intolerance
O Excessive Sweating
O Hot Flashes
O Hair Changes

Genitourinary:
O Painful Urination
O Frequent Urination
O Blood in Urine
O Nighttime Urination
O Discharge
O Difficulty w/ erection
O Low Sex Drive
O Abnormal Menstrual Cycle
O Breast pain/nipple discharge

Respiratory
O Chest Congestion
O Cough
O Cold Symptoms
O SOB/Wheezing

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Agreement of Financial Responsibility

Clinic Responsibilities:

- Prove accurate and timely billing
- Provide your bill to you in a paper statement

Patient Financial Responsibilities:

- Provide your **insurance card** at each visit to ensure that we bill your insurance correctly
- Please be familiar with your insurance coverage and limitations. This is a contract between you and your insurance company. It is your responsibility to know your benefits. We do not have control over your coverage or co-pay rates. It is also your responsibility to determine whether the plan is 'in network' with the physician. Out of network plans will accrue higher costs.
- **Co-payments** are to be paid at each visit
- We will bill you primary and secondary insurance company first; any remaining balance will be billed to you. Patient due balances noted on your monthly statement are due within 30 days of receipt.
- Some insurance plans do not cover certain procedures, such as newborn circumcisions, employment exams, sports physicals and treatment of cosmetic skin lesions. In such cases, you will be asked to sign a waiver agreeing to pay for the visit at the time of service. You may want to call your insurance company to determine coverage for a procedure that is being considered.
- For our self-pay patients, we require payment in full at the time of your service.
- We require at least 24-hour notice if you are unable to keep your appointment. Missing an appointment without notice and/or arriving too late to be seen is considered a no show and is subjected to a $50.00 penalty.
- Accounts delinquent beyond 60 days will be subject to transfer to an outside collection agency at the patient's expense. Repeated failure to pay may results in patient dismissal from the clinic.

Updates to this policy can be found on our website. Please let us know if you have any questions. Call our Billing Department at **541-672-7718 option 1.**

I have read, understand, and agree to the above Agreement of Financial Responsibility. I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Patient Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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No Show and Late Arrival Policy

Thank you for choosing Holmes Family care for your medical needs. We schedule our appointments with the aim to provide each patient the right amount of time to receive the highest quality of care. While we understand that life is unpredictable, any time a patient misses an appointment another patient is prevented from receiving care. These policies are in place to give us time to schedule other patients who may be waiting for care and to ensure that patients who arrive on time do not wait longer than necessary to see the provider.

Rescheduling:

If a patient needs to cancel or reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to the scheduled appointment time. Office phone number is: 541-672-7718. **If the office doesn't answer, please leave a message with name of patient, date of birth and appointment time.**

No Show Policy:

Patients that no show their appointment without cancelling at least 24 hours prior to appointment time will be considered a **"No Show."**

After the second no show, patient will be charged a fee of $50.00. This fee **must** be paid before a patient can be seen.

After the third no show and/or cancellation/reschedule without 24-hour notice, patient may be dismissed from the practice.

Late Arrival Policy:

If a patient is more than 10 minutes late from the scheduled appointment time, the appointment will be rescheduled. Patient will be given the option to wait for a later appointment time on the same day if one is available.

If patient arrives more than 10 minutes late for their new patient appointment or arrive at the scheduled appointment time without completed registration forms, patient may be asked to reschedule.

Insurances **will not** reimburse for these fees therefor it will be assessed directly to the account guarantor.

By signing below, I am acknowledging having read and understanding the Polices and Fee's outlined above and agree to its terms.

Patient Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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Protected Health Information Disclosure

Please provide a list of all individuals we may speak with in regards to the patient's medical information including; leaving a message in regards to medical care, appointment scheduling or confirming, and payment information or account balances.

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This undesigned patient or patient representative agrees as follows:

1. Authority is granted to Holmes Family Care to render needed treatment to the patient.
2. I authorize release of information about my medical history, lab/imagining results, billing questions, confirming and scheduling appointments to the individuals above.
3. I authorize Holmes Family Care to release information regarding my treatment to my insurance company for billing purposes.
4. I authorize payment of medical benefits to Holmes Family Care for services rendered.
5. I understand that I am responsible for all charges incurred through Holmes Family Care.
6. Authorization Period: O One year **OR** O Lifetime

I request that payment under the medical insurance program be made to Holmes Family Care on any bills for services furnished me during the effective period of this authorization and I authorize the above name Holmes Family Care to release to the Social Security Administration any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original. If this becomes necessary to effect collection of my account the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and court costs.

You may receive an additional bill from our office if you received additional services during your visits. This may be but is not limited to: injections, immunizations, urine test, etc.

Patient Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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Patient Rights and Responsibilities

Patient Rights:

- To receive care that is considerate and respectful, without discrimination of any kind based on race, color, sex, language, religion, political, national or social origin, disability, age, martial and family status, sexual orientation and gender identity, health status, place of residence or economic and social situation.
- Get up-to-date, complete and honest information
- Have things explained in the language you want to use.
- Know all the facts we have about your illness, treatments and what may happen.
- Know the name and specialty of the people taking care of you.
- Agree or disagree to treatment options (as allowed by law)
- Take part in planning and carrying out your care.
- Have privacy with all your records, when your provider examines you and talks with you (as allowed by law)
- Know how your doctor works with the other places that take care of you.
- Be evaluated and treated for pain
- Be treated right away if you might die, even if you don't have insurance or cannot pay.
- To agree to an Advance Directive, such as a health care proxy.
- Get a detailed explanation and a copy of your bill.
- If you have a complaint, we must respond to you in a reasonable amount of time.
- See, copy, correct or restrict use of the information in your medical record (as allowed by law)
- Decline to being examined, observed or treated by a student or staff member. If so, you will still be treated.
- Get quick responses to questions or concerns.

Patient Responsibilities:

- Be seen in clinic at **least once a year** per insurance requirements.
- Show respect, consideration and dignity to all clinic employees.
- Communicate completely and honestly about current health and past medical history, includes medications, past illnesses or hospitalizations.
- Ask questions when something is unclear with your care.
- Notify us if there might be a problem with your care.
- Notify the clinic if you believe we did not respect your rights, if you have a complaint or an idea how we can improve our practice.
- Help the clinic be a safe place. If you see an unsafe situation or unsafe behavior, notify us.
- Try to follow the treatment plan that was discussed during your appointment. If unable to do so, please let the provider know.
- Pay your co-pay and balance when you are here. If unable to, contact our office to discuss payment options.
- If unable to make appointment, please notify the clinic within 24 hours of appointment time.
- Do not carry weapons of any kind into the clinic.
- Notify the clinic if there is any change to address, telephone number, or insurance plan.
- Notify the clinic if there is change to make to your Advanced Directive or Health Care Proxy forms. (Advance Directive notifies us what kind of care you want if, in the future, you're unable to discuss this. Health Care Proxy notifies us on who can make decisions about your care, if someday patient is unable to make decisions of themselves.

I have received a copy of and have read all my rights and responsibilities, or they have been read to me, and I understand them.

Printed Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

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Acknowledgement & Consent

I understand that Holmes Family Care will use and disclose health information about me.

I understand that my health information may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Holmes Family Care may use and disclose my health information in order to:

- Make decisions about the plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I understand that I have the right to receive and review a written description of how Holmes Family Care will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff, and other office personnel of Holmes Family Care, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Holmes Family Care Notice of Privacy Practices is available at the front desk.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Holmes Family Care is not required by law to agree to such request.

By signing below, I agree that I have reviewed and understand the information above and that I have been offered my own personal copy of the Notice of Privacy Practices.

Printed Name: _____ DOB: _____

Patient (Parent/Guardian) Signature: _____ Date: _____

Name: _____ DOB: _____

Annual questionnaire

Once a year, all our patients are asked to complete this form because drug and alcohol use can affect your health as well as medications you may take.

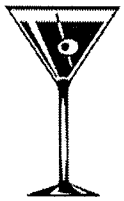
Please help us provide you with the best medical care by answering the questions below.

Are you currently in recovery for alcohol or substance use? ☐ Yes ☐ No

Alcohol: One drink =

12 oz. beer

5 oz. wine



1.5 oz liquor (one shot)

	None	1 or more
MEN: How many times in the past year have you had 5 or more drinks in a day?	○	○
WOMEN: How many times in the past year have you had 4 or more drinks in a day?	○	○

**** If answered 1 or more, go to page 3.

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	○	○

**** If answered 1 or more, go to page 4.

Developed by SBIRT Oregon, http://www.sbirtoregon.org/resources/annual_forms/Annual%20-%20English.pdf

Name: _____ DOB: _____

Patient Health Questionnaire and General Anxiety Disorder

(PHQ-9 and GAD-7)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several Days	More than half days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add the score for each column:				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

---

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column:				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

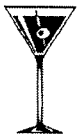
Not difficult at all Somewhat difficult Very difficult Extremely difficulty

Name: _____ DOB: _____

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help up provide you with the best medical care by answering the questions below.

One drink equals: 

12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for alcohol use? ☐ Never ☐ Currently ☐ In the past

Name: _____ DOB: _____

Drug Screening Questionnaire (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Which of the following drugs have you used in the past year?

o methamphetamines (speed, crystal)
o cannabis (marijuana, pot)
o inhalants (paint thinner, aerosol, glue)
o tranquilizers (valium)
o cocaine
o narcotics (heroin, oxycodone, methadone, etc.)
o hallucinogens (LSD, mushrooms)
o other: _____

How often have you used these drugs? ☐ Monthly or less ☐ Weekly ☐ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse or family ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes

Have you ever injected drugs? ☐ Never ☐ Yes, in the past 90 days ☐ Yes, more than 90 days ago

Have you ever been in treatment for substance abuse? ☐ Never ☐ Currently ☐ In the past

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Authorization for Release of Protected Health Information

Holmes Family Care is committed to protecting the privacy of information about you and your health. This means that in many cases, we must obtain you authorization in order to disclose protected health information about you. Please read the information below carefully before signing this form.

Patient Name: _____ DOB: _____ Phone: _____

Records request from:

Name of Facility: _____

Adress: _____

Phone: _____ Fax: _____

Records to use or disclose to:

Holmes Family Care Phone: 541-672-7718 Fax: 541-315-7125
2564 NW Edenbower BLVD Ste 126 Roseburg, OR. 97471

_____ I authorize the release of my **compete** medical records. This authorization for release of information covers the period of health care from: Start Date: _____ to _____

Please initial beside the options below to authorize the release of sensitive information pertaining to:

_____ Mental Health
_____ Drugs or Alcohol
_____ Genetic Testing
_____ HIV/AIDS/other infectious diseases

This information may be used by the person I authorize to receive this information for medical treatment or consultations, billing, or claims payment, or other purposes as I may direct.

- **I understand that this authorization is voluntary, and that I may results to sign it.**
- **I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.**
- **I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.**
- **I understand that I have the right to receive a copy of this authorization.**
- **I understand that I have the right to inspect or copy the information to be disclosed.**
- **I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on the authorization.**

By signing below, I acknowledge that I have read and accept all of the above.

_____
Signature of Patient or Representative

_____
Printed Name of Patient or Representative Date: