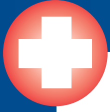

New Patient Information

Authorization To Release Information To Family Members

Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must complete this form. Signing this form will only give consent to release this information to the family members indicated below. You have a right to revoke this consent in writing.

I authorize/allow Hugh Chatham Surgical to release my medical and/or billing information to the following:

1. Name: ______________________ Relation To Patient: ______________
2. Name: ______________________ Relation To Patient: ______________
3. Name: ______________________ Relation To Patient: ______________
4. Name: ______________________ Relation To Patient: ______________

Patient Name ______________________ *Date of Birth* ______________________

Signature of Patient ______________________ *Date* ______________________

Authorization to Leave Messages with Household Members/Answering Machine

Occasionally it is necessary to leave messages for patients to remind them of an appointment, to notify the patient that the staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of this office discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

Patient Name ______________________ *Date of Birth* ______________________

Signature of Patient ______________________ *Date* ______________________

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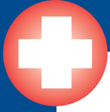

New Patient Information

Pre-Consent Form for Treatment of a Minor/Dependant

This pre-consent form allows parents of minors or legal guardians of dependant adults to grant permission for other responsible adults to bring their child or dependant adult to our office for evaluation or treatment.

The undersigned parent/guardian of: ______________________________

Whose date of birth is: ______________________________

Does hereby empower the following named individuals

1. Name: ____________________ Relation To Patient: ____________
2. Name: ____________________ Relation To Patient: ____________
3. Name: ____________________ Relation To Patient: ____________
4. Name: ____________________ Relation To Patient: ____________

Express permission to act as my agent to consent to and authorize medical evaluation and treatment for my above/ child dependent. This authorization provides authority and power on the part of the above named individuals to give specific consent to any and all such evaluation, diagnosis, office treatment, immunization administration, anesthetic administration, or surgical treatments which a physician, in the exercise of his/her judgement, may deem advisable. This authorization includes hospital admission if such is deemed necessary by the physician.

This authorization shall be valid until or unless revoked by me in writing.

I do hereby indemnify and hold harmless the physicians, staff, an other persons who act in reliance upon this authorization.

Parent/Guardian Name ____________________ *Date of Birth* ____________________

Parent/Guardian Signature ____________________ *Date* ____________________

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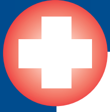

New Patient Information

Authorization for Release of Medical Records

I, ____, do hereby consent and authorize

____

to release to Hugh Chatham Surgical all medical records relating to my (or my dependant child's) identity, diagnosis, prognosis and treatment, psychiatric treatment, diagnosis and/or treatment of HIV or related illnesses, sickle cell disease, or hepatitis. I understand the extent or nature of the medical information to be disclosed includes:

____

____

Furthermore, I understand that this authorization is revocable by me at any time should I provide a written, signed notice to Hugh Chatham Surgical, except to the extent that any action has already been taken on this release. Otherwise, consent will remain in force for 90 days.

Special Limitation of restrictions, if any: ______________________________________

____

______________________________ ______________________________

Signature of Patient *Date*

______________________________ ______________________________

Signature of Witness *Date*

______________________________ ______________________________

Signature of Parent/Legal Guardian *Date*

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