| PATIENT INFORMATION: (Please use full legal name, no nicknames.)    Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ Cell Phone Number: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_Work Number (\_\_\_) \_\_\_\_-\_\_\_\_  Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| --- |
| GUARANTOR INFORMATION (List person or insured name responsible for bill- use full legal name, no nicknames.)  Relationship of Guarantor to Patent: Self\_\_\_\_\_Spouse\_\_\_\_Parent\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Phone number: (\_\_\_\_) \_\_\_\_-\_\_\_\_\_ Cell phone number: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_Work number (\_\_\_) \_\_\_\_-\_\_\_\_  Social Security number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Employer Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards.)  *IF SOMEONE OTHER THAN PATIENT IS THE INSURED PARTY, PLEASE INCLUDE DATE OF BIRTH FOR CLAIMS*  PRIMARY INSURANCE:  Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy/ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Claims Address & Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SECONDARY INSURANCE:  Plan Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy/Id Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Claims Address & Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Basic Information:**  First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **List ALL current medications, dosage, and directions:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **List ALL allergies and reactions:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **List ALL surgeries:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**MEDICAL HISTORY FORM**

**ADULT RISK FACTOR QUESTIONNAIRE**

|  |
| --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tobacco Use (all forms of Tobacco)  *Please circle all that apply*  Never used tobacco products  Current everyday user: Yes or No, if yes please circle what type of tobacco product below  Cigarette Cigar Pipe Smokeless  Number of Packs Per Day\_\_\_\_\_ number of cans per day\_\_\_\_\_\_\_\_\_\_ years of use\_\_\_\_\_\_\_\_  Current someday user: Yes or No, if yes please circle what type of tobacco product below  Cigarette Cigar Pipe Smokeless  Number of Packs Per Day\_\_\_\_\_ Number of Cans Per Day\_\_\_\_\_\_\_\_\_\_ Years of Use\_\_\_\_\_\_\_\_  No Longer Use Tobacco: Year Quit\_\_\_\_\_\_ Packs Per Day\_\_\_\_\_\_\_\_ Years of Use\_\_\_\_\_\_\_\_  Passive Smoke/ Are You Exposed to Tobacco Users? Yes or NO  Drug Use: Yes or No  If Yes List Substances \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Caffeine Usage: Yes or No, If Yes How Many Drinks Per Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Alcohol Use: Yes or No  Dinks Per Day: \_\_\_\_  Have You Felt the Need to Cut Down? Y or N  Felt Guilty About Drinking? Y or N  Need an Eye Opener I the Morning? Y or N  Do You Exercise? Yes or No  How Many Times Per Week? \_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  First Name M.I. Last Name |

|  |
| --- |
| **ASSIGNMENT OF INSURANCE BENEFITS:**  I hereby authorize direct payment of my insurance benefits to Pueblo West Primary Care or the Providers individually for services rendered to my dependents or myself by the provider or under his / her supervision. I understand that it is my responsibility to know my insurances benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balances due that Pueblo West Primary Care is unable to collect from my insurance carrier. I agree to forward all health insurances or third-party payments that I receive for services rendered to me immediately upon receipt.  **Medicare/Medicaid:**  I certify that any information I provide, if any, in applying for payment under Title XVIII (Medicare) or Title XIX(Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Pueblo West Primary Care by the Medicare of Medicaid program.  **Financial Agreement:**  I acknowledge, that as courtesy, Pueblo West Primary Care may bill my insurance company for services provided to me. I agree to pay for services that are not covered or covered charges not paid in full including but not limited to any co-payments, co- insurances and/ or deductible, or charges not covered by insurances. I acknowledge that failure to pay for services not covered by insurances may result in termination from Pueblo West Primary Care. I understand that a 25$ fee will apply for returned checks. I understand and agree there is a 25$ fee for no showing an appointment or for cancelling an appointment that was not canceled within 24 hours of the scheduled appointment time. I acknowledge that Pueblo West Primary care may utilize the services of a third-party business associate or affiliated entity as an extended business office for medical account billing and servicing.  **Lab/Diagnostic Services:**  I understand that I may receive a separate bill if my medical care includes labs, x-rays, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurances for whatever reason.  **HIPPA PRIVACY & RELEASE OF INFORMATION AUTHORIZATION**  I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members listed below.  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If Pueblo West Primary Care needs to contact me and I am unavailable, I authorize them to leave me a detailed message that may be included but not limited to test results, medications and referrals.  Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**PATIENT REGISTRATION FORM DISCLOSURES & CONSENTS**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

|  |
| --- |
| I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:   * Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. * Obtain payment from third party payers. * Conduct normal healthcare operations such as quality assessments and physician certifications.   I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Pueblo West Primary Care, LLC has the right to change its Notice of Privacy practices from time to time and that I may contact Pueblo West Primary Care, LLC at any time at the address above to obtain a current copy of the Notice of Privacy Practices.  I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.  Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **OFFICE USE ONLY** |
| I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:   * The patient refused to sign. * Due to an emergency situation, it was not possible to obtain an acknowledgement. * We weren’t able to communicate with the patient. * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Employee Signature: Date: |

**MEDICAL RELEASE FORM**

|  |  |  |
| --- | --- | --- |
| Patient information:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  | | --- | --- | | Health information released FROM:  Pueblo West Primary Care: \_\_  Other: \_\_  Person/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State? Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ | Health information released TO:  Pueblo West Primary Care: \_\_  Other: \_\_  Person/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City/State? Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |
| --- | --- |
| Health Information to be RELEASED: | Please circle all that apply or enter specific dates of treatment  Date(s) of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Clinic Visit Radiology reports  Labs Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Immunizations  **All Information regarding chemical dependency treatment, mental health and /or HIV or AIDS WILL BE RELEASED unless you check one of the following below:**  \_\_\_\_\_\_ Do Not Release Chemical Dependency Treatment records  \_\_\_\_\_\_ Do Not Release Mental health records  \_\_\_\_\_\_Do Not Release HIV/AIDS records |
| Purpose of Release: | Please circle all that apply  Personal Attorney Continued care Appt date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Disability/Social Security Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Transfer from Practice/Reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **There may be a charge/ fee for copies for records** |
| Delivery Method: | Please circle all that applies  Mail Fax Pick up by patient/authorized designee (requires valid photo ID) |
| Authorization/Revocation: | This authorization will terminate in one year unless otherwise specified: \_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that I may stop this release at any time by contacting Pueblo West Primary Care. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be redisclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that Pueblo West Primary Care will not provide further treatment once care has been transferred. Any outstanding bill must be paid prior to records being released. I understand I must sign this form to release my health information.  X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date  (If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law)  Relationship to patient (if not patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Staff Use only: | Info released by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_ |