Ninth Street Internal Medicine- AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

805 Locust Street. Philadelphia, PA 19107 Office (215) 440-8681 Fax (215) 440-9953

_____ _____
(**Print** Patients Full Name) Birth Date (Mo/Day/Yr)

_____ _____
Street Address Social Security Number

_____ _____
City, State, Zip Phone (Home)

At the request of the individual, I _____, do hereby
(Patient's Name)

Authorize:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip

To Release DATES OF: _____

___HISTORY & PHYSICAL ___LABORATORY REPORTS ___ IMMUNIZATION RECORDS
___PROGRESS NOTES (last 2 years) ___RADIOLOGY REPORTS ___PAP SMEAR RESULTS (2 years)
___DIAGNOSTIC TESTS (e.g. colonoscopy, mammogram) ___OTHER _____

Initial Below:

____I DO ____I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: ***NINTH STREET INTERNAL MEDICINE***

PURPOSE OF DISCLOSURE:

____REFERRAL TO SPECIALIST ____INSURANCE ____WORKERS COMP
✓___CHANGE OF DOCTOR ____LEGAL INVESTIGATION ____DISABILITY DETERMINATION
____PERSONAL ____CONTINUING CARE
____OTHER (SPECIFY) _____

Please provide current telephone number in the event we need to contact you: _____

MY RIGHTS:

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual or Guardian or Personal Representative of Patient's Estate **Date**

Form Date 04/15

NINTH STREET INTERNAL MEDICINE PATIENT NAME: _____ DATE OF BIRTH: _____

APPOINTMENT DATE: _____

NEW PATIENT

Personal Information

Personal Details

NAME: _____ DATE OF BIRTH: _____

MARITAL STATUS: _____ GENDER: _____

Address Details

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

Contact Details

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

Other Details

PCP: _____ REFERRING DOCTOR: _____

Emergency Contact Details

LAST NAME: _____ FIRST NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

RELATION: _____

Additional Information

Pharmacy

LOCAL PHARMACY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

Street Address (if different from mailing address)

MAIL ORDER PHARMACY NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

Please turn over and complete other side

NEW PATIENT
Personal Information

Employer

NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

Contacts 1 [Optional]

LAST NAME: _____ FIRST NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

RELATION: _____

Contacts 2 [Optional]

LAST NAME: _____ FIRST NAME: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

RELATION: _____

COMPLETE PHYSICAL NEW PATIENT

Social History

Marital Status:
☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Number of People in Household:
☐ 1 ☐ 2 ☐ 3 ☐ 4+

Highest Education Level:
☐ Some High School ☐ High School ☐ Some College ☐ College ☐ Grad School ☐ Post Graduate ☐ Other

Occupation:

_____

How is your life in general?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Disastrous

Special Diet?

_____

DO YOU HAVE ANY OF THE FOLLOWING?

Constitutional
Falls? ☐ Yes ☐ No
Fatigue? ☐ Yes ☐ No

Cardiology
Chest Pain? ☐ Yes ☐ No
Shortness of Breath? ☐ Yes ☐ No
Palpitations? ☐ Yes ☐ No
Leg Swelling? ☐ Yes ☐ No

Dermatology
Rash? ☐ Yes ☐ No

ENT
Nasal congestion? ☐ Yes ☐ No
Sore throat? ☐ Yes ☐ No
Hearing loss? ☐ Yes ☐ No
Post-nasal drip? ☐ Yes ☐ No
Dizziness? ☐ Yes ☐ No

Gastroenterology
Abdominal Pain? ☐ Yes ☐ No
Nausea? ☐ Yes ☐ No
Vomiting? ☐ Yes ☐ No
Heartburn? ☐ Yes ☐ No

Gastroenterology
Indigestion? ☐ ☐
Diarrhea? ☐ ☐
Constipation? ☐ ☐
Change in bowel habits? ☐ ☐
Blood in stool? ☐ Yes ☐ No
Hemorrhoids? ☐ Yes ☐ No

Hematology/Lymph
Bleeding problems? ☐ Yes ☐ No
Clotting problems? ☐ Yes ☐ No

Musculoskeletal
Joint Pain? ☐ Yes ☐ No
Back Pain? ☐ Yes ☐ No

Neurology
Headache? ☐ Yes ☐ No
Tingling/Numbness? ☐ Yes ☐ No
Visual Changes? ☐ Yes ☐ No
Memory Loss? ☐ Yes ☐ No

Psychology
Anxiety? ☐ Yes ☐ No
Sleep disturbances? ☐ Yes ☐ No

Urology
Urinary frequency? ☐ Yes ☐ No
Urinary Urgency? ☐ Yes ☐ No
Blood in urine? ☐ Yes ☐ No
Urinary incontinence? ☐ Yes ☐ No
Kidney stone? ☐ Yes ☐ No

Exercise:
☐ Never ☐ Occasional ☐ 2-3 days per week ☐ 3-5 days per week ☐ Every Day

Does a partner from a current or past relationship make you feel unsafe?
☐ Yes ☐ No

Alcohol Use? Number of Drinks
☐ Daily ☐ Weekly ☐ Never

Any questions about sex you would like to discuss with your doctor?
☐ Yes ☐ No

Regular dental care?
☐ Yes ☐ No

Recreational drug use?
☐ Yes ☐ No

Guns in the house?
☐ Yes ☐ No

Regular eye care?
☐ Yes ☐ No

Home smoke detector use?
☐ Yes ☐ No

NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

New Complete Physical Adult Health Assessment Form

Please complete this form in advance of your first physical appointment. Be sure to bring it with you. Use pencil or pen and completely fill in only one circle per question for the attached bubble sheets. The following information is confidential. It is used to evaluate your health and risk factors for disease.

Name_____ Appointment Date_____
Date of Birth_____ Age_____ Birthplace_____
Spouse/Partner's Name_____
Spare time activities_____

What **problems** do you wish to discuss with the doctor during your evaluation today?

_____
_____
_____
_____
_____

Please list the **other doctors** you see regularly:
name _____specialty_____

_____
_____
_____
_____
_____

Please list your **allergies** to medication
Drug_____ Reaction_____

_____
_____
_____
_____
_____
_____

Please list **food and environmental allergies** such as smoke/pollen.

_____
_____
_____
_____
_____
_____

Please list all your regular **medications** *including* birth control, *over-the-counter medicines, vitamins and health food store products*. Please include dosage (strength) and number of times per day.

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

Past **Surgical History** please circle and write *date* and *name* of surgeon:

Tonsillectomy_____ Uterus removed (reason)_____
Appendix removed_____ Ovaries removed (one, both and reason) _____
Gallbladder removed_____ C-section(s)_____
Hernia repair (side and type) _____ Hemorrhoid surgery_____
Joint replacement (specify joint(s)) _____
Other Surgeries_____

NINTH STREET
INTERNAL MEDICINE ASSOCIATES, LTD.

Immunization/Vaccine history *with dates if possible*:

O Tetanus or **O** Tetanus/Pertussis_____
Influenza (flu) _____
Pneumovax/Pneumonia _____
TB test/PPD and result_____
Meningitis_____
Other_____

Varicella (chicken pox) **O** vaccine or **O** disease_____
Zoster/Shingles vaccine_____
Hepatitis B (3 shots)_____
Hepatitis A (2 shots)_____
MMR_____
HPV_____

Screening tests with *dates* and *name of provider or hospital*:

Last complete physical exam:_____
Colonoscopy_____
PSA (prostate cancer blood test) –men only_____
Pap Test – women only_____
Mammogram – women only_____
DXA bone density scan_____

Family History:

Relationship	Current Age *or* Age at Death		Significant Medical Problems
Mother	_____	_____	_____
Father	_____	_____	_____
#of Brothers ____	_____	_____	_____
#of Sisters ____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse/Partner	_____	_____	_____
#of Children ____	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
#of Grandchildren ____			

Please indicate if any of the above relatives *or* if any grandparents, aunts, uncles have these diseases:

Yes	No		Yes	No	
___	___	asthma	___	___	kidney disease/dialysis
___	___	arthritis	___	___	kidney stones
___	___	blood clotting /bleeding disorder	___	___	alcohol/drug problem
___	___	diabetes	___	___	mental illness/suicide
___	___	stroke	___	___	osteoporosis
___	___	glaucoma/macular degeneration	___	___	cancer (circle type and give age):
___	___	heart attack/atherosclerosis			breast, ovarian, colon, prostate,
___	___	high blood pressure			melanoma, other_____
___	___	high cholesterol	___	___	other_____

Patient Name: _____ Date:_____

Past Medical History

Do you have any of the following health conditions? If yes, please include any further information you wish to give us.

Please circle the correct response:			**COMMENTS:**
YES	NO	Hypertension	_____
YES	NO	Heart Disease	_____
YES	NO	Diabetes	_____
YES	NO	High Cholesterol	_____
YES	NO	Asthma	_____
YES	NO	Cancer	_____
YES	NO	Kidney Disease	_____
YES	NO	Liver Disease	_____
YES	NO	Thyroid Disease	_____
YES	NO	Reflux/Gastritis	_____
YES	NO	Prostate Disease	_____
YES	NO	Osteoporosis	_____
YES	NO	Anxiety	_____
YES	NO	Depression	_____
YES	NO	Sexually Transmitted Disease	_____
YES	NO	Arthritis	_____
YES	NO	Stroke	_____
YES	NO	Other	_____

2015 HIPAA Privacy Authorization Form

NINTH STREET INTERNAL MEDICINE ASSOCIATES, INC.

Authorization for use or disclosure of protected health information. (Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)
Please list names and relationships of all persons that you authorize Ninth Street Internal Medicine Associates to release your medical information to during the course of your care:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I hereby authorize all medical sources to release and disclose the following protected health information to:

Ninth Street Internal Medicine Associate
805 Locust Street
Philadelphia, PA 19107
Phone: 215-440-8681
Fax: 215-440-9953

Specific information to be disclosed:	The information for which I'm authorizing disclosure will be used for the following purpose:
☐ Entire Medical Record Only information related to (specify): _____	☐ Further Medical Care
☐ Only the period of events from to(please describe):_____	☐ Personal Use
☐ Other: (please describe) _____ _____	☐ Other (please describe): _____ _____

Important Information About Your Rights

I understand that my records are protected under the Health Insurance Portability and Accountability Act, Federal Privacy Act, P.L. 93-575, the Federal Alcohol and Drug Abuse Act, P.L. 92-282, the Pennsylvania Mental Health Procedures Act, 1976 and the Pennsylvania Confidentiality of HIV Related Information Act, and therefore cannot be disclosed without my written consent unless otherwise provided for in the regulations. Under the Mental Health Act, this authorization expires one (1) month from the date of my signature. Under the Federal Alcohol and Drug Abuse Act, this authorization shall become void ninety (90) days from the date of my signature. In addition, I understand that I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to the Ninth Street Internal Medicine and/or that my consent expires under the circumstance above. I understand that once copies of my information are provided, NSIM cannot prevent re-disclosure by the recipient. I understand that any information disclosed in response to this request will NOT include information related to my treatment for AIDS/HIV, psychiatric care/treatment, treatment for drug/alcohol, unless I specifically consent to release of this information by checking any or all the boxes below:

☐ AIDS/HIV Information ☐ Psychiatric Care/Treatment ☐ Treatment for Drug and Alcohol use/abuse

_____ _____
Signature of Patient/Patient Representative Date of Signature

_____ _____
Printed Name of Patient/Patient Representative Relationship to Patient

_____ (Initial) I acknowledge that I have been provided a copy of Ninth Street's Internal Medicine's Notice of Privacy Practices explaining my rights and permitted uses and disclosures with regard to my protected health information.

_____ (Initial) I acknowledge that this authorization is only good for one calendar year.

2015 HIPAA Privacy Authorization Form

NINTH STREET INTERNAL MEDICINE ASSOCIATES, LTD.

AUTHORIZATIONS
ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.
I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance, and any other health plan to Ninth Street Internal Medicine Associates, Ltd. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

Signature of patient or responsible party **Date**

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Ninth Street internal Medicine Associates Ltd for any services furnished me by Ninth Street Internal Medicine Associates, Ltd.
I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of related services.

Medicare Beneficiary Signature **Date**

Medicare Number Medigap Plan

In Compliance with Medicare regulation we are required to ask the following questions:

Do you or your spouse work for a company that provides you with health benefits? ☐Yes ☐No
Are you entitled to Medicare because of disability or End Stage Renal Disease? ☐Yes ☐No
Is the illness of injury the result of an automobile accident or other injury? ☐Yes ☐No
Has treatment for the accident or illness been authorized by the Veterans Administration? ☐Yes ☐No
Are you entitled to any benefits under the Federal Black Lung Program? ☐Yes ☐No

I certify that this information is true and complete to the best of my knowledge

Signature_____ **Date**_____