Getting Started with Compassion Care Family Practice

- Please fill out the new patient packet completely. Incomplete packets will delay the process. *This includes reading the controlled substance policy and reading and signing the financial policy*.

  PERMISSION TO RELEASE MEDICAL RECORDS is where you list your *previous provider* so we can request your records. Please list as much information as you can. If you do not list a previous provider, we cannot request any medical records.

  AUTHORIZATION TO SHARE MEDICAL INFORMATION is where you list a spouse, family member, caregiver, etc., that we are allowed to share information about you with.

- Please place a call to your insurance company to verify that Marci Cogdill, FNP-C is a preferred provider or in network, and to make her your primary care provider with your insurance. ***You will be responsible for charges incurred that your insurance will not cover.***

- A copy of the front and back of your ID and insurance card will be required before being seen.

- Once your packet is processed, our office will call to set up an appointment to establish care. ***Please not that the initial establish care visit is a "get to know each other" visit. In addition we can discuss your most important medical issue. Future appointments will be scheduled to handle additional issues.***

Patient Registration Form

Compassion Care Family Practice, LLC

Compassion Care Family Practice - Marci Cogdill FNP-C:
610 Hawthorne Ave S - Suite 250, Salem, OR 97301 ● Phone:(503) 559-3312 ● Fax:(855) 868-6823

Patient Information

First Name	M.I.	Last Name		
Preferred Name	**Date of Birth**	**Sex**	**SSN**	

Race: (check one)
☐ Asian ☐ American Indian/Alaska Native ☐ White
☐ Decline to Answer ☐ Native Hawaiian/Pac. Islander ☐ Black/African American ☐ Other

Ethnicity: (check one)
☐ Hispanic/Latino
☐ Decline to Answer ☐ Not Hispanic/Latino

Marital Status	Primary Language

Mailing Address

City	State	Zip

Home Phone	Work Phone	Cell Phone	Preferred Phone: (check one)
			☐ Home ☐Work ☐Cell

Fax Number (if applicable)	Email Address

Preferred Method of Communication
□Mail □Phone □Email □Fax □Text Message □Secure Patient Portal

Guarantor Information: (Person who is financially responsible)

☐ *Check here if same as above*

First Name	M.I.	Last Name	Sex	Date of Birth	SSN

Mailing Address	City	State	Zip	Marital Status

Home Phone	Work Phone	Cell Phone	Preferred Phone: (check one)
			☐ Home ☐Work ☐Cell

Relationship to Patient	Email Address

Emergency Contact Information:

First Name	Last Name	Relationship to Patient

Contact Number	Alternate Contact Number

Preferred Pharmacy Information:

Pharmacy Name	General Location (city and/or street name)

For Office Use Only:	*PC:*		*Initials*	*Date*
*Date Rcv'd:*_____		*Reg. Info*	_____	_____
		Facesheet	_____	_____

Patient Registration Form

Compassion Care Family Practice - Marci Cogdill FNP-C:
610 Hawthorne Ave S - Suite 250, Salem, OR 97301 ● Phone:(503) 559-3312 ● Fax:(855) 868-6823

Name:_____

Please complete the information below or supply us with a copy of your insurance card(s), both front & back:

☐ *Check here if you do not have insurance* **Primary Insurance Information:**		
Name of Insurance Company	**ID/Policy Number**	**Group Number**
Address of Insurance Company	**Do you have a co-pay?** ☐ No ☐ Yes - amount_____	**Phone Number**
Policy Holder (person carrying insurance)	**Policy Holder's Date of Birth & SSN**	**Relationship to Patient**

Secondary Insurance Information: (if applicable)		
Name of Insurance Company	**ID/Policy Number**	**Group Number**
Address of Insurance Company	**Do you have a co-pay?** ☐ No ☐ Yes - amount_____	**Phone Number**
Policy Holder (person carrying insurance)	**Policy Holder's Date of Birth & SSN**	**Relationship to Patient**

Please complete the information below if you are seeing us due to an automobile accident:

Automobile Insurance Information: (if applicable)		
Name of Insurance Company	**Claim Number**	
Claims Address for Insurance Company		**Date of Accident**

Patient Registration Form

Compassion Care Family Practice, LLC

Compassion Care Family Practice - Marci Cogdill FNP-C:
610 Hawthorne Ave S - Suite 250, Salem, OR 97301 ● Phone:(503) 559-3312 ● Fax:(855) 868-6823

Name:_____

Personal Health History

(Please fill out your Health History information as accurately as possible. This information is a confidential record)

Have you ever had the following? Check all that apply

AIDS ☐	Blood Transfusion ☐	Gastric Ulcer ☐	Hiatal Hernia ☐	Mitral Valve Prolapse ☐
Alcoholism ☐	Bronchitis ☐	Genital Herpes ☐	Inguinal Hernia ☐	Mononucleosis ☐
Anemia ☐	Cancer (what kind) ☐	Genital Warts ☐	HIV ☐	Mumps ☐
Anorexia ☐	_____	GERD ☐	High Cholesterol ☐	Osteoporosis ☐
Anxiety ☐	Chickenpox ☐	Glaucoma ☐	High Blood Pressure ☐	Pneumonia ☐
Irregular Heart Beat ☐	Chlamydia ☐	Goiter ☐	Erectile Dysfunction ☐	Rheumatic Fever ☐
Arthritis ☐	Depression ☐	Gonorrhea ☐	Irritable Bowel ☐	Scarlet Fever ☐
Asthma ☐	Diabetes Type I ☐	Gout ☐	Kidney Disease ☐	Stroke ☐
Back Pain ☐	Diabetes Type II ☐	Hearing Loss ☐	Kidney Infection ☐	Thyroid Disease ☐
Bipolar Disorder ☐	Drug Addiction ☐	Heart Attack ☐	Kidney Stone ☐	Tuberculosis ☐
Bladder Infections ☐	Eczema ☐	Heart Disease ☐	Liver Disease ☐	Whooping Cough ☐
Legally Blind ☐	Emphysema ☐	Hemorrhoids ☐	Measles ☐	
Blood Disorder ☐	Epilepsy ☐	Hepatitis ☐	Migraines ☐	

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all medications and supplements you take regularly (if necessary, attach additional sheet of paper)

Medication	Dose	Frequency (how often)	Prescribing Physician (or state if over the counter)

Please list all medication allergies and the reaction you have. ☐ **No Known Drug Allergies**

Allergic To:	Reaction	Allergic To:	Reaction

Social History: **(**circle your answer)

Do you smoke? **Never** **Quit** – when? _____ **Yes** – how much/how often? _____

Do you use smokeless tobacco? **Never** **Quit –** when? _____ **Yes** – how much/how often? _____

Do you drink alcohol? **Never** **Quit** – when?_____ **Yes** – how much/how often? _____

Do you use illegal drugs? **Never** **Former** **Yes** – what kind, how much/how often? _____

Do you use caffeine? **No** **Yes** – what kind/how often? _____

How much exercise do you get? **Sedentary** **1-2 times/month** **1-2 times/week** **3-4 times/week** **nearly every day** **daily**

Do you have a living will or advance directive? **Yes** **No** (if yes, please supply us with a copy for our records)

Are you Adopted? **Yes** **No**

Patient Registration Form

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Name:_____

Family Health History:

Has any blood relative had any of the following? Be as specific as possible; for example "maternal grandmother"

Problem	Family Member	Age Onset	Problem	Family Member	Age Onset
Alcohol Abuse			Epilepsy		
Allergies			Glaucoma		
Anemia			Heart Disease		
Asthma			High Cholesterol		
Blood Disorder			High Blood Pressure		
Cancer – what kind			Kidney Disease		
			Migraines		
Depression			Stroke		
Diabetes Type I			Thyroid Disease		
Diabetes Type II			Tuberculosis		

Women Only:

Menstrual Cycle

Age your period began: _____

Menopause: **No** **Yes**, since age _____

How many days do your periods last? _____

Length of entire cycle: _____

Menstrual Flow: **Light** **Medium** **Heavy**

Do you spot between periods? **No** **Yes**

Date your last period started: _____

Birth Control Method (circle all that apply)

Virgin Abstinence None

Natural Family Planning Withdrawal

Condoms Foam/Gel Diaphragm

IUD Pill Patch Nuvaring Depo

Vasectomy Tubal Hysterectomy

Essure Implanon

Pregnancies

Have you ever been pregnant? **No** **Yes**

How many children have you had? _____

Are they all living? **No** **Yes**

Have you had a miscarriage? **No** **Yes**

If yes, how many? _____

Have you had an abortion? **No** **Yes**

If yes, how many? _____

What is your reason for transferring care to Compassion Care Family Practice?

_____

_____

If you are in need of an appointment right away, what do you need to be seen for?

_____

_____

How did you hear about Compassion Care Family Practice?

☐ Yellow Pages ☐ Referred by a patient (patient's name)_____

☐ Web Search ☐ Other (please specify)_____

_____ Initial

By initialing here I acknowledge that I have had the opportunity to read a copy of **Compassion Care Family Practice's Notice of Privacy Practices** and I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I understand that I have the right to revoke this consent at any time by giving written notice to Compassion Care Family Practice. I also understand that I do not have to initial this space.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Compassion Care Family Practice or my insurance company to release any information required to process my claims.

Signature Date

Effective April 14, 2003

Notice of Privacy Practices

Compassion Care Family Practice, LLC

Compassion Care Family Practice - Marci Cogdill FNP-C:
610 Hawthorne Ave S - Suite 250, Salem, OR 97301 ● Phone:(503) 559-3312 ● Fax:(855) 868-6823

This notice describes how medical information about you may be used and/or disclosed, and how you can get access to this information. Please review it carefully.

Our Commitment to Your Privacy

Compassion Care Family Practice (CCFP) understands that the medical information about you and your health is personal, and we are committed to protecting it. We create a record of the care and services you receive from our clinic in order to provide you with quality care. CCFP, is required by law to provide you with this Notice of Privacy Practices describing our legal duties concerning your PHI.

The law requires us to:

- Make sure that medical information is kept private.
- Provide you with this Notice of Privacy Practices.
- Follow the terms of this Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI):

The following categories describe different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. We may also provide your PHI to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and/or treat you.

Payment: We may use and disclose your PHI to obtain payment for your health care services. For example, obtaining approval for advanced imaging services may require that your relevant PHI be disclosed to the health plan.

Healthcare Operations: We may use or disclose your PHI in order to support the business activities of your physician's practice. These uses and disclosures are necessary for administration and to ensure that all of our patients receive quality care. For example, we may disclose your PHI to medical school students that see patients in our office. We may also call you by name in the waiting room when your physician is ready to see you.

Appointment Reminders: We may use or disclose PHI to contact you to remind you that you have an appointment for treatment or medical care at our office.

Health-Related Benefits and Services: We may use or disclose your PHI to tell you about health-related benefits or services that may be of interest to you. For example we may offer a new service to patients with a certain condition. Our staff may contact you directly based on your PHI to offer you this new service.

Individuals Involved in Your Care or Payment for Your Care: We may use or disclose your PHI when talking with a friend or family member who is involved in your medical care at our office. We may also use or disclose your PHI when interacting with someone who helps pay for your care. **If you do not want us to make these disclosures, you must notify us in advance.**

To Avert a Serious Threat to Health or Safety: We may use or disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of others. Any disclosure; however, would only be to someone able to help prevent the threat.

Public Health Risks: We may use or disclose your PHI for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease
- To report abuse, neglect or domestic violence. As required or authorized by law

Law Enforcement: We may use or disclose your PHI if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of crime if, under certain limited circumstances, we are unable to obtain the person's consent
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our office
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

Special Situations: We may use or disclose your PHI without your authorization in the following situations. These situations include:

- Health Oversight Activities – Examples include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- Lawsuits and Disputes – Only in response to a court or administrative order
- Coroners, Medical Examiners and Funeral Directors
- Organ and Tissue Donation
- Military, Veterans and National Security – As required by military command or authorized federal officials
- Workers' Compensation
- Inmates or Individuals in Custody of a Law Enforcement Official – We may release PHI to the correctional institution or officials when necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES AND DISCLOSURES OF SPECIALLY PROTECTED INFORMATION:

Oregon and Federal law provide additional confidentiality protections in the following circumstances:

- HIV – In Oregon, healthcare providers generally may not release the identity of a person tested for HIV or the results of HIV-related testing without your specific consent and you must be notified of this confidentiality right.
- Drug & Alcohol – These records are specially protected and typically require your specific consent for release under both Federal and State law.

- Mental Health – These records are specially protected in some circumstances and typically require your specific consent for release under both Federal and State law.
- Genetic Information – Genetic information is specially protected and typically requires your specific consent for release under both Federal and State law.

YOUR RIGHTS REGARDING YOUR PHI:

You have the following rights regarding the use and disclosure of your PHI:

Right to Inspect and Copy: You have the right to inspect and copy your PHI that may be used to make decisions about your care. Usually this includes medical and billing records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

To inspect and copy your medical information that CCFP, SMM uses to make decisions about you please contact our medical records department at (503) 559-3312. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility

- To request an amendment, please contact the CCFP, SMM Privacy Officer for a form.
- We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.
- We may deny your request to amend information that:
    - Was not created by us
    - Is not part of the medical information kept by or for our office.
    - Is not part of the information which you would be permitted to inspect and copy.
    - Is accurate and complete.

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures we have made of your PHI in the previous six years, beginning April 14, 2003. You are not entitled to an accounting of disclosures made for the purposes of treatment, payment and health care operations; disclosures you authorized; disclosures to you; incidental disclosures; disclosures to family or other persons involved in your care; disclosures to correctional institutions and law enforcement in some circumstances; disclosures of limited data set information; or disclosures for national security or law enforcement purposes.

To request an accounting of disclosures from CCFP, SMM please contact the SFP Privacy Officer to request a form.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example you could ask that we not use or disclose information about a surgery you had.

Your practitioner is not required to agree to your request. If the practitioner believes that it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional. If your practitioner does agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, please contact the Privacy Officer to request a form.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications please contact the Privacy Officer for a form.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice please ask at our reception desk.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the reception area of each of our offices. The notice will contain on the first page, in the top left corner, the effective date.

COMPLAINTS:

If you believe that your privacy rights have been violated, you may direct your complaint to the Privacy Officer in writing. Please contact our office to request a form. If we cannot resolve your issue, you also have the right to file a written complaint with the US Department of Health and Human Services, Region X, Office for Civil Rights, 2201 6th Avenue, Ste. 900, Seattle, WA 98121.

We will not penalize you or retaliate against you in any way for filing a complaint.

OTHER PERMITTED USES AND DISCLOSURES OF PHI:

Other uses and disclosures of your PHI not covered by this notice or the laws that apply to us will only be honored with your written consent. If you provide us with permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided you.

PRIVACY OFFICE AND CONTACT PERSON:

If you have any questions about this Notice of Privacy Practices or wish to object or complain about any use or disclosure as explained above, please contact the Privacy Officer as listed below. Please note that the Notice of Privacy Practices for all clinics are mailed to the information below.

Compassion Care Family Practice
Attn: Marci Cogdill
610 Hawthorne Ave, S - Suite 250
Salem, OR 97301
(503) 559-3312
marci@compassioncarefamilypractice.com

Compassion Care Family Practice, LLC

New Patient Controlled Substance Policy:

Our goal is to safely improve function and quality of life. We practice evidence based medicine and follow the set forth guidelines for controlled substances. These include narcotics, benzodiazepines and stimulants. Unfortunately, there is a high potential for tolerance, dependence and side effects with these medications . Therefore prescribing such medicine is tightly regulated and must be carefully monitored.

-No new patient will be given a prescription for a controlled substance on the first visit.

-Pain control may first be attempted with non-controlled medication / methods.

-For any patient currently on a controlled substance, the provider must have previous medical records from prior prescribing providers.

-In most cases (excluding cancer patients / palliative care / post-surgical patients and those patients currently in facilities on controlled substances) the provider will slowly taper doses each month at a safe rate until the medication can be discontinued, or a referral will be placed to a prescribing Pain Management Clinic.

-We care about the health, function and quality of life for each patient. Practicing safe medicine is our highest priority.

Hopefully you read and abide by the requirements we listed. Thank you from the staff of Compassion Care Family Practice.

Compassion Care Family Practice - Marci Cogdill FNP-C:
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Compassion Care Family Practice, LLC

Financial Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are insured by a plan we are not contracted with, we will attempt to submit a claim on your behalf, but often times these claims will be paid at an 'out of network' rate. You may be billed for the remaining balance. **Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.**

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You may be billed for these services or required to pay for these services in full at the time of visit.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us at or before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Payment at Time of Visit.** Our office offers a 20% discount to patients without insurance who pay for services received on the date of their visit. We are able to offer this discount because of the costs we save in billing you. If you have received a bill for these services we will not be able to give you the discount.

8. **Payment Plans.** Our office is happy to work with our patients to arrange payment plans. We are willing to find a payment that works for your budget. We will not charge interest, we simply ask that a payment be made every month. In the event that you do not make a payment for 3 consecutive months, your account will be referred to our collection agency.

9. **Nonpayment.** Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. We will consider seeing you as a patient once your entire balance has been paid to the collection agency.

10. **Bankruptcy.** In the event that you file bankruptcy and our office must write off your balance, you and your immediate family members will be discharged from our practice. We will not be able to consider seeing you in the future.

11. **Missed appointments.** Our policy is to charge for missed appointments. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Permission to Release Medical Records

Patient's Name: _____
First Middle Last

Date of Birth: _____ SSN: _____

Permission is hereby granted to release information:

From: _____
Clinic / Doctor / Individual Name

Address: _____

_____

_____ _____
Phone Fax

Reason for release: _____ Changing Doctors _____ Other: _____

Medical records to be released to:

Compassion Care Family Practice - Marci Cogdill FNP-C:
610 Hawthorne Ave S - Suite 250, Salem, OR 97301 ● Phone:(503) 559-3312 ● Fax:(855) 868-6823

The following information may be released:

_____ Most Recent 3 years

_____ Other (_____)
Specify information to be released

The following information will not be released without specific authorization. Please initial to authorize the release of the following information:

_____ Drug/Alcohol
Initial

_____ Mental Health
Initial

_____ HIV
Initial

Expiration Date of this authorization will be 1 year from the date this release was signed unless revoked or terminated by the patient or the patient's representative. You may submit a written revocation to the sender of the original records at any time. Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulation

Signature Relationship Date

Compassion Care Family Practice, LLC

Authorization to Share Medical Information

Patient Name:_____

Date of Birth:_____

Social Security Number:_____

I authorize sharing medical information with the following:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

I authorize sharing of the following information (please check all that apply)

____ No information can be shared

____ Any information can be shared

____ Can authorize release of my medical records or obtain copies of my medical records

____ Billing information

____ Other (please specify)_____

This authorization will remain in effect (please check only one):

____ From the date this is signed until (date) _____

____ Until I cancel this authorization in writing

____ Until the following occurs (please specify)_____

By signing this I authorize the disclosure of all information checked above. I acknowledge I have reviewed and understand this authorization form.

Signature: _____ Date: _____

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