

New Patient Information Form

Name of child (or children) and DOB:

Name: _____ DOB _____ M/F Appt reason: _____

Name: _____ DOB _____ M/F Appt reason: _____

Name: _____ DOB _____ M/F Appt reason: _____

Name: _____ DOB _____ M/F Appt reason: _____

Parent/Guardian name: _____ DOB: (parent/guardian): _____

Primary Phone: _____ Alternate Phone: _____

Email: _____

Address:

Insurance(s): Primary: _____

Secondary: _____

Previous provider(s) information:

Practice/MD name: _____ City: _____ State: _____

Phone: _____ Fax: _____

Notes: _____

For office use only:

Mona Cawley, NP

Dr. Cole Webster

Joye Griffn, NP

Kelly Grummer-Smith, NP

Flavia Rossi, MD

Nalitia Zow, NP

Dr. Nikkia Johnson

Allsha Holloway, NP

TIFT REGIONAL HEALTH SYSTEM, INC.
TIFT REGIONAL MEDICAL CENTER/
SOUTHWELL MEDICAL, A CAMPUS OF TIFT REGIONAL MEDICAL CENTER

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____
Date of Birth: _____

Medical Record Number: _____
Last 4 digits of SS Number: _____

1. Facility(ies): I authorize representatives from the following facility(ies) to disclose the health information as directed below:
- Tift Regional Medical Center
 - Southwell Health and Rehabilitation
 - Southwell Medical, a campus of TRMC
 - Southwell Medical Rural Health Clinic; list _____
 - Other: _____

2. Description of health information to be disclosed: (check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> problem list | <input type="checkbox"/> most recent discharge summary |
| <input type="checkbox"/> medication list | <input type="checkbox"/> most recent history and physical |
| <input type="checkbox"/> physician orders | <input type="checkbox"/> physician progress notes |
| <input type="checkbox"/> laboratory results | from date _____ to date _____ |
| <input type="checkbox"/> x-ray / imaging reports | from date _____ to date _____ |
| <input type="checkbox"/> x-ray films | from date _____ to date _____ |
| <input type="checkbox"/> consultation reports | from (doctor's name) _____ |
| <input type="checkbox"/> entire record | from date _____ to date _____ |
| <input type="checkbox"/> billing records | from date _____ to date _____ |
| <input type="checkbox"/> other _____ | |

3. I understand that these records may contain information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), drug abuse, alcoholism, sickle cell anemia, and behavior or mental health services.

4. This information may be disclosed to and used by the following individual or organization:

Name: Affinity Pediatrics Phone Number: 229-353-7337
Address: 39 Kent Road St.5 Tifton, Georgia 31794

Via: Paper CD Electronic Delivery (include e-mail address) _____

5. Purpose of disclosure: (check all that apply)

- Legal Issue Insurance Claim Personal Use Certified Copy
 Continuing Care Other (explain): _____

6. I understand that this Authorization, except for action already taken, may be revoked by me at any time. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to the Health Information Management Department, PO Box 2560, Tifton, GA 31793, (229) 353-6120. I understand that this Authorization will expire on _____ (insert expiration date or event). If I do not specify an expiration date or event, this Authorization will expire one year from the date on which I signed this Authorization.

7. I understand that the facility will not condition treatment, payment, enrollment, or eligibility for benefits concerning my health care on whether I sign or refuse to sign this authorization.

8. I understand that authorizing the disclosure of this health information is voluntary and that disclosure of such information carries with it the potential for unauthorized re-disclosure.

Signature of Patient or Legal Representative

Date

Time

Print Name

Relationship to Patient

Signature of Witness

Date

Time

