

Evansville Multi-Specialty Clinic, PC

6140 E Columbia Street Evansville, IN 47715
Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 • www.evansvilleclinic.com

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

Please Print all information

Patient Name: _____ Date: _____

Social Security Number: _____ DOB: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____

I hereby authorize the release of PHI from the following provider/facility:

(Name of Facility or Provider to release the information from)

I hereby authorize the release of PHI to the following provider/facility:

(Name of Facility or Provider you want the information to be released to)

Information to be released: (please check one of the following)

- Entire Records including all: HIV/AIDS, psychological progress notes or mental health
 All records excluding the following: HIV/AIDS, psychological progress notes or mental health documentation.
 Other: (please specify) _____

Dates of the information to be released:

All

Or From: _____ to: _____

Purpose of the release of PHI: (please check one of the following)

- Continuity of Care (referrals or transferring care to another provider)
 Legal
 Personal
 Insurance/Workman's compensation
 Other: (please specify) _____

I am aware that such records may contain information related to mental health, substance abuse (alcohol/drug use) and sexually transmittable diseases including HIV/AIDS as long as I specifically authorized the release of such information pursuant to this authorization. I understand this authorization will remain in effect for 1 year, but may be revoked at any time in writing. I further understand that any such revocation will not apply to any information already released under this authorization. I understand that I am under no obligation to sign this authorization and that my ability to obtain treatment will not depend on such authorization. I understand that I have a right to receive a copy of this authorization. I understand that State and Federal law may prohibit the recipient from re-disclosing information pursuant to this authorization. I hereby release Evansville Multi-Specialty clinic, PC from any and all liability related to reliance upon this authorization or the release of information pursuant to this authorization.
FEE FOR COPIES: Federal and state laws permit a fee to be charged for copying of patient records. Please see additional fee sheet for charges that apply. All fees must be collected prior to releasing your information.

Signature of Patient/or Authorized Person(s) _____ Date: _____

Relation to Patient if Patient unable to sign: _____

Witness: _____ Signature of Witness: _____

For Office Use only

Release Date: _____ # of pgs: _____ Certified Y N via: mail fax pick up Completed by initials: _____



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812-475-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 • www.evansvilleclinic.com
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Name: _____

Past Medical History: If you are offended by the personal nature of a question please do not answer

<p>General Health Issues:</p> <input type="checkbox"/> Weight Gain/Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sleep Problems <p>Eyes:</p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Visual Changes <input type="checkbox"/> Double vision <input type="checkbox"/> Corrective Lenses <input type="checkbox"/> Itchy Eyes <p>Ears/Nose/Mouth/Throat:</p> <input type="checkbox"/> Ear Pain <input type="checkbox"/> Difficulty in hearing <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Runny Nose <input type="checkbox"/> Post Nasal drip <input type="checkbox"/> Mouth sore/Ulcer <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Pain on swallowing <input type="checkbox"/> Hoarseness <p>Breasts:</p> <input type="checkbox"/> Pain <input type="checkbox"/> Lump/mass <input type="checkbox"/> Nipple discharge	<p>Respiratory :</p> <input type="checkbox"/> Difficultly Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Regular Sputum production <input type="checkbox"/> Exercise induced cough/wheezing <input type="checkbox"/> Asthma <p>Cardiovascular:</p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pain/tightness <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart attack <input type="checkbox"/> Leg pain <input type="checkbox"/> Leg swelling <p>Integumentary/Skin:</p> <input type="checkbox"/> Skin color/texture <input type="checkbox"/> Itching <input type="checkbox"/> Rashes <input type="checkbox"/> Ulcers <input type="checkbox"/> Worrisome growths	<p>Gastrointestinal:</p> <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating/belching <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Change in bowels <input type="checkbox"/> Bloody stool <input type="checkbox"/> Black, tarry stools <input type="checkbox"/> Hemorrhoids <p>Urinary and Genital:</p> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain on urination <input type="checkbox"/> Hesitancy <input type="checkbox"/> Incontinence <input type="checkbox"/> Awake at night to urinate <input type="checkbox"/> Problems with erection/impotence <input type="checkbox"/> Prostate problems <input type="checkbox"/> Decreased interest In sex <p>Musculoskeletal:</p> <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle/bone pain	<p>Neurological:</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <p>Psychiatric:</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Feel sad or down <input type="checkbox"/> Decreased interest in normal activities <input type="checkbox"/> Mood Swings <p>Endocrine:</p> <input type="checkbox"/> Thyroid problem <input type="checkbox"/> Frequent thirst <input type="checkbox"/> Excessive sweating <p>Hematologic/Lymphatic:</p> <input type="checkbox"/> Easy bruising <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Swollen Lymph nodes
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Past Medical History:

Please check if you suffer from, or have been treated for any of the following medical conditions:

- Hypertension () Diabetes () Heart Attack () Asthma () Stroke () HIV (AIDS) () Obesity
 Congestive Heart Failure () High Cholesterol () Arthritis () History of blood transfusions
 Cancer: What kind and when? _____

Have you been admitted to a hospital during the past five years? () Yes () No

If yes, reason for admission: _____

Past Surgical History:

Please list any surgeries you have had and the year:

Current Medications:

Please list any prescribed and over the counter medication you are currently taking:

Medication_____	Dosage_____	How Often:_____
Medication_____	Dosage_____	How Often:_____
Medication_____	Dosage_____	How Often:_____
Medication_____	Dosage_____	How Often:_____
Medication_____	Dosage_____	How Often:_____

Allergies:

Do you have any allergic or adverse reactions to any medications or substances? () Yes () No

If yes, please list (and your reaction):

Social History:

Smoke () Yes () No If yes, # of cigarettes/packs_____ per day/week (Quit date:_____)

Alcohol () Yes () No If yes, # of glasses per day/week_____

Do you use any illicit (street) drugs? () Yes () No If yes, please list_____

Do you exercise? () Yes () No If yes, how many times per week? _____

Please check the appropriate box: () Married () Single () Widowed () Divorced () Separated

Number of children:_____

Family History:

Please check if any of the following diseases run in you family, and if yes, indicate which relative(s):

Hypertension () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Diabetes () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Heart Disease () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Stroke () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Cancer () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Osteoporosis () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Glaucoma () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Mental Illness () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Drug/Alcohol Addiction () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N

Sexual History:

Are you sexual active? () Yes () No If yes, are you active with () men () women () both

For Women only:

Are you pregnant? () Yes () No Nursing? () Yes () No Births?_____ Miscarriages?_____

Are you taking birth control? () Yes () No Last Menstrual Period:_____ Age of Onset?_____

Frequency:_____ Length of Period:_____ Last Mammogram:_____

Prolonged or abnormal bleeding? () Yes () No

Last pap smear:_____ History of abnormal pap smears: () Yes () No

Screening:

Last physical exam:_____ Cholesterol Level:_____ Colonoscopy:_____

PSA testing:_____ Digital rectal exam:_____ Stool Cards:_____

X _____
Patient/Guardian Signature Date