

**YOUR VISIT**

Dear Patient,

**Welcome to Genesis Medical Group!**

Our goal here at Genesis Medical Group is to provide you with the highest level of care and get you back to living life to the fullest.

We want to make your first appointment an easy and pleasant experience. Here are a few reminders about your first appointment:

* Please bring the following items to your new patient appointment:
* Medical insurance card
* Driver’s license or state id
* Medical records, we will request your medical records that need authorization. Bring all records you have in your possession as well.
* Current medication list
* Allergy list
* Completed new patient forms

Please plan to arrive to your appointment 30 minutes prior to your scheduled appointment time, this will allow you to complete the new patient paperwork if you have not completed beforehand. The new patient paperwork is located on our website at [www.genesisdoctors.com](http://www.genesisdoctors.com).

Please be prepared to spend up to two hours at your first appointment; your first appointment will be a comprehensive visit including a physical exam and review of your medical history. We also want to allow enough time for you to communicate any questions or concerns you may have.

Be prepared with a list of questions for your physician; this will allow you to effectively communicate all your questions during your appointment.

We will verify your insurance and obtain any required referrals/authorizations prior to your appointment. In the event we encounter any issues in verifying or obtaining referral/authorization we will contact you prior to the appointment.

Your copay or patient responsibility will be due at the time of service.

If you have any questions regarding your new patient appointment please contact our new patient coordinators at

832-289-5801.

We look forward to meeting you at your first appointment and taking care of your healthcare needs.

Sincerely,

Genesis Medical Group



**NEW PATIENT MEDICAL QUESTIONNAIRE**

Please complete this questionnaire by answering each question as accurately as possible.

**GENERAL INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female

Social Security:\_\_\_\_\_\_ -\_\_\_\_\_\_ -\_\_\_\_\_\_\_ Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( \_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Cell/Wk: : ( \_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Advertising Facebook Insurance Co. Hospital Patient in the Practice

Primary Care Doctor Specialists Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widow \_\_\_ Other

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: ( \_\_\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_

**CHIEF COMPLAINT/REASON FOR VISIT**

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing any pain? (circle one) **YES NO** , if yes where is the pain location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you marked yes**, please indicate on the scale of 1 to 10 with 10 being the highest your level of pain **1 2 3 4 5 6 7 8 9 10**

**MEDICATIONS**

Please list all prescriptions and over-the-counter medication you take on a regular basis. **(If you have a list readily available, please give copy to the front desk)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dose (ex. 50mg)** | **Frequency (ex. Once a day)** | **Reason for Taking** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**ALLERGIES**

Are you allergic to any medications? **YES NO** if yes please list medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to intravenous contrast? **YES NO** if yes please list your reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other allergies? Incl. Latex **YES NO** if yes please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PHARMACY INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

**1**. Select All That Apply:

\_\_\_Current smoker, every day \_\_\_Current smoker, some days \_\_\_ Smoker, status unknown

\_\_\_ Light tobacco smoker \_\_\_Heavy tobacco smoker \_\_\_ Former Smoker \_\_\_ Never Smoker

Cigarettes Amount: \_\_\_\_\_ per day Cigars Amount: \_\_\_\_\_ per day

Smokeless Amount: \_\_\_\_\_ per day Pipes Amount: \_\_\_\_\_ per day

**2)** Have you had exposure to second hand smoke? (circle one) **YES** or **NO**

**3)** Do you drink alcoholic beverages? (circle one) **YES** or **NO**, if yes how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Please list if any of your family members below have or had any of the following diseases or medical conditions: ***Bleeding/Clotting Disorders, Cancer (list type if known), Diabetes, Heart Disease, Hypertension, Leukemia, Lymphoma, Heart Attack, or stroke.***

Mother: **Alive Deceased** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: **Alive Deceased** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sister(s): **Alive Deceased** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brother(s): **Alive Deceased** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandmother: **Maternal Paternal** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandfather: **Maternal Paternal** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aunts: **Maternal Paternal** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Uncles: **Maternal Paternal** Age: Medical Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST MEDICAL HISTORY**

**1)** Have you had any of the following tests within the last 6 months? (Select All That Apply, if yes where and when?)

Pet Scan When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CT Scan When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ultrasound When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (specify) When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2)** Have you been hospitalized in the last 6 months? **YES NO**

If YES, when and reason for hospitalization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**REVIEW OF SYSTEMS**

Check the symptoms you currently have or have had in the past year. Please check all that apply.

|  |  |  |
| --- | --- | --- |
| **GENERAL**  ­­­\_\_\_ Chills  \_\_\_ Depression/Nervousness  \_\_\_ Dizziness/Fainting  \_\_\_ Excessive Weight Gain or Loss  \_\_\_ Fever  \_\_\_ Headache  \_\_\_ Numbness | **CARDIOVASCULAR**  \_\_\_ Chest Pain  \_\_\_ High/Low Blood Pressure  \_\_\_ Irregular/Rapid Heart Beat  \_\_\_ Poor Circulation  \_\_\_ Shortness Of Breath  \_\_\_ Swelling In Ankles  \_\_\_ Varicose Veins | **SKIN**  \_\_\_ Any Chronic Rashes Or Eruptions  \_\_\_ Change In Moles  \_\_\_ Hives  \_\_\_ Itching  \_\_\_ Irregular Scars  \_\_\_ Poor Healing Of Lesions or Wounds  \_\_\_ Poor Healing Of Foot Lesions |
| **EYE, EAR, NOSE, & THROAT**  \_\_\_ Bleeding Gums  \_\_\_ Blurred Vision  \_\_\_ Crossed Eyes  \_\_\_ Difficulty Swallowing  \_\_\_ Double Vision  \_\_\_ Earache Or Ear Discharge  \_\_\_ Hay Fever  \_\_\_ Hoarseness  \_\_\_ Loss of Hearing  \_\_\_ Nosebleeds  \_\_\_ Persistent Cough  \_\_\_ Ringing In Ears  \_\_\_ Sinus Problems  \_\_\_ Vision – Flashes or Halos | **GASTROINTESTINAL**  \_\_\_ Bloating  \_\_\_ Black Or Tarry Stools  \_\_\_ Bowel Changes  \_\_\_ Change In Appetite  \_\_\_ Constipation  \_\_\_ Diarrhea  \_\_\_ Excessive Thirst  \_\_\_ Gas  \_\_\_ Hemorrhoids  \_\_\_ Indigestion/Heartburn  \_\_\_ Nausea  \_\_\_ Rectal Bleeding  \_\_\_ Stomach Pain  \_\_\_ Vomiting | **HEMATOLOGIC**  \_\_\_ Anemia  \_\_\_ Easy Bruising  \_\_\_ Excessive Bleeding  **RESPIRATORY**  \_\_\_ Chronic Cough  \_\_\_ Coughing Up Blood  \_\_\_ Wheezing Or Asthma  **URINARY**  \_\_\_ Blood In Urine  \_\_\_ Frequent Urination  \_\_\_ Lack Of Bladder Control  \_\_\_ Painful Urination |
| **NEUROLOGICAL**  \_\_\_ Double Vision/Vision Loss  \_\_\_ Prior Stroke  \_\_\_ Muscular Weakness/Tingling  \_\_\_ Speech Difficulty  \_\_\_ Transient Paralysis  \_\_\_ Transient Neurologic Deficit  **MUSCLE/BONE/JOINT**  \_\_\_ Pain, Weakness, Numbness In:  \_\_\_ Arms  \_\_\_ Back  \_\_\_ Feet  \_\_\_ Hands  \_\_\_ Hips  \_\_\_ Legs  \_\_\_ Neck/Shoulders | **MEN ONLY**  \_\_\_ Erection Difficulties  \_\_\_ Lump In Testicles  \_\_\_ Penis Discharge  \_\_\_ Sore On Penis  \_\_\_ Other Issue | **WOMEN ONLY**  \_\_\_ Abnormal Pap Smear  \_\_\_ Bleeding Between Periods  \_\_\_ Breast Lump  \_\_\_ Extreme Menstrual Pain  \_\_\_ Hot Flashes  \_\_\_ Nipple Discharge  \_\_\_ Painful Intercourse  \_\_\_ Vaginal Discharge  Date of Last Period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_  Date of Last Mammogram: \_\_\_\_\_\_\_\_\_\_  Are you pregnant? Yes or No  Number of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



**REVIEW OF SYSTEMS CONTINUED**

Circle all the conditions you have or have had in the past.

|  |  |  |  |
| --- | --- | --- | --- |
| Aids  Atrial Fibrillation  Appendicitis  Arthritis  Asthma  Bleeding Disorders  Blood Clots  Breast Lump  Cancer  Cataracts  Chemical Dependency | Chicken Pox  COPD  Diabetes  Emphysema  Epilepsy  Glaucoma  GERD  Heart Disease  Hepatitis  Herpes  High Cholesterol | HIV Positive  Kidney Disease  Liver Disease  Measles  Migraine Headaches  Multiple Sclerosis  Mumps  Pacemaker  Pneumonia | Polio  Prostate Problem  Rheumatic Fever  Scarlet Fever  Stroke  Thyroid Problems  Tuberculosis  Ulcers  Venereal Disease |

**Surgical History**

**SIGNATURES**

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my

doctor if I ever have a change in health.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Personal Representative Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name of Patient or Personal Representative Relationship to Patient**



**ADVANCE DIRECTIVES INFORMATION SHEET**

An **advance directive** is a legal document that tells your family, friends and healthcare professionals the care you would like to have if you become unable to make medical decisions. Through advance directives, you can make legally valid decisions about your future medical treatment.

You do not need a lawyer to complete your advance directives. However, you should be aware that each state has its own laws for creating advance directives.

There are three advance directives recognized in Texas:

• The **Texas Medical Power of Attorney** appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. Your attending physician must certify in writing that you are unable to make health care decisions and file the certification in your medical record. If you would like more information and a copy of the Texas Medical Power of Attorney form please ask the front desk staff.

• A **living will**, officially known in Texas as the Directive to Physicians and Family or Surrogates, describes the kind of medical treatments or life-sustaining treatments you would want if you were seriously or terminally ill. A living will should be signed, dated and witnessed by two people, preferably individuals who know you well but are not related to you and are not your potential heirs or your health care providers. If you would like more information and a copy of the Directive to Physicians and Family Members form please ask the front desk staff.

• The **Out-of-Hospital Do Not Resuscitate (DNR) order** provides you with the right to withhold or withdraw cardiopulmonary resuscitation (CPR) or other treatments such as defibrillation and artificial ventilation. If you would like more information and a copy of the Texas Department of Health Services Standard Out of Hospital Do Not Resuscitate form please ask the front desk staff.

By creating an advance directive, you are making your preferences about medical care known before you're faced with a serious injury or illness. This will spare your loved ones the stress of making decisions about your care while you are sick. Any person 18 years of age or older can prepare an advance directive.

In order to make your directive legally binding, you must sign it, or direct another to sign it, in the presence of two witnesses who must also sign the document.

It is our responsibility to inform all competent adult patients about Advance Healthcare Directives and ask whether they have one in place. The staff is instructed to know the different types of advance directives. All staff members know where to direct patients who have questions or want more information about advance directives. If a patient provides an advance directive to Genesis Physicians, the physicians and staff should know the patients’ decisions related to treatment.



**ADVANCE DIRECTIVES CONFIRMATION FORM**

Under Texas law you have the right to make decisions concerning your healthcare. The rights include the right to accept or refuse medical treatment and the right to create advance directives to make preferences about your medical care. In the state of Texas any person age 18 years or old who is legally competent has the right to make these decisions in advance.

Advance directives recognized in Texas are the Texas Durable Medical Power of Attorney, a Living Will, and an Out of Hospital Do Not Resuscitate. No patient can be discriminated against for exercising their right to elect and create advance directives.

**Advance Healthcare Directives Confirmation:**

* **YES**, I have an Advance Healthcare Directives *(select which advance directive you have below).*
  + Texas Durable Medical Power of Attorney
  + Living Will, officially known as the Directive to Physicians and Family or Surrogates
  + Out of Hospital Do Not Resuscitate (DNR)

\*\*\**If you have selected YES, please provide a copy of your advance directive to the front office staff.*

* **NO**, I do not have Advance Healthcare Directives *(select which advance directive you have below).* I understand that I can request more information about advance directives.
  + I have received the information sheet about advance directives.
  + I would like additional information about the three advance directives recognized in Texas.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print) Patient Signature





**PATIENT AUTHORIZATION TO COMMUNICATE AND DISCLOSE**

**PROTECTED HEALTH INFORMATION**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternative means or communicated to authorized designated parties including family members.

**I wish to be contacted in the following manner *(Check All That Apply):***

**­­­\_\_\_ Home Telephone \_\_\_ Cell Telephone**

\_\_Leave message with detailed information. \_\_Leave message with detailed information.

\_\_Only leave message with call back details. \_\_Only leave message with call back details.

**\_\_\_ Work Telephone \_\_\_ Written Correspondence**

\_\_Leave message with detailed information. \_\_ Mail to my home address on file

\_\_Only leave message with call back details. \_\_ Email to address on file

I hereby authorize one or all of the designated parties below to request, discuss, and receive any protected health

information regarding my healthcare and treatment. This PHI includes my treatment information, billing, payments, or

any information in my medical records. I understand that the identity of designees must be verified before release of

PHI.

**Authorized Designees:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: (\_\_\_\_\_ ) -\_\_\_\_\_-\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: (\_\_\_\_\_ ) -\_\_\_\_\_-\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: (\_\_\_\_\_ ) -\_\_\_\_\_-\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: (\_\_\_\_\_ ) -\_\_\_\_\_-\_\_\_\_\_\_\_

***This authorization shall remain in effect from the date signed below until revoked.***

***You have the right to revoke this authorization in writing.***

• ***I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.***

• ***I understand information disclosed to any above designees is no longer protected by federal or state law and may be subject to redisclosure by the above designee.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Representative Print Name Patient/Legal Representative Signature Date



**PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: ( \_\_\_\_\_) – \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

**I hereby authorize:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name of Provider/Hospital/Physician Provider/Hospital/Physician Address Telephone Number

To release the following information from my health record covering the period of

From \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_ , if I do not specify a period I am authorizing the release of records for entire duration of care with the provider. *(check all that apply below)*

\_\_\_\_Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical Records). ***If this box is checked, do not check any additional boxes.***

\_\_\_\_ Progress/Office Visit Notes \_\_\_\_ Radiology/Imaging Reports \_\_\_\_Chemotherapy/Radiation Records

\_\_\_\_ Lab Reports \_\_\_\_ Pathology Reports \_\_\_\_ Billing/Payment Records

**Information is to be released to:**

Genesis Medical Group \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: (\_\_\_\_\_ ) -\_\_\_\_\_- \_\_\_\_\_\_\_ Fax: (\_\_\_\_\_ ) -\_\_\_\_\_- \_\_\_\_\_\_\_

Office Address

**The information is being released for the following purposes:**

\_\_\_\_ Continued Care/Treatment \_\_\_\_ Disability \_\_\_\_ Attorney/Litigation \_\_\_\_ Other

**I understand that this authorization will remain in effect until I revoke it in writing.**

I understand that according to applicable state and or/federal laws (Texas Medical Practice Act or Health Insurance

Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other

health care provider involved in my care or treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Legal Representative Print Name Patient/Legal Representative Signature Date