

Patient Record of Disclosure

NAME OF PATIENT OR INDIVIDUAL

Last First Middle \_\_\_\_\_

OTHER NAME(S) USED \_\_\_\_\_

DATE OF BIRTH Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ ALT. PHONE (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS (Optional): \_\_\_\_\_

I wish to be contacted in the following manner (check all that apply)

\_\_\_ Home phone number \_\_\_\_\_

\_\_\_ Cell phone number \_\_\_\_\_

**Written Communication**

ok to leave message with detailed info

ok to mail to my home address

leave message with call back number only

ok to mail to work/office

ok to fax to this number

\_\_\_ Work Telephone \_\_\_\_\_

ok to leave message with detailed info

leave message with call back number only

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name *Terre Haute Internal Medicine*

Address *420 East Hospital Lane*

City *Terre Haute* State *IN* Zip Code *47802*

Phone *(812)238-0958* Fax *(812) 238-0960*

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person Name \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

Person Name \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

Person Name \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

Person Name \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- All health information
- History/Physical Exam
- Past/Present Medications
- Lab Results
- Physician's Orders
- Patient Allergies
- Operation Reports
- Consultation Reports
- Progress Notes
- Discharge Summary
- Diagnostic Test Reports
- EKG/Cardiology Reports
- Pathology Reports
- Billing Information
- Radiology Reports & Images
- Other \_\_\_\_\_

Your initials are required to release the following information:

- Mental Health Records (excluding psychotherapy notes)
- Genetic Information (including Genetic Test Results)
- Drug, Alcohol, or Substance Abuse Records
- HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional) \_\_\_\_\_

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE

X \_\_\_\_\_  
Signature of Individual or Individual's Legally Authorized Representative

DATE \_\_\_\_\_

# Patient Registration

Patient Name: \_\_\_\_\_  
DOB \_\_\_\_\_

Race: Please circle one of the following

- Hispanic      Black or African American      White      American Indian/Alaska Native  
Asian: Native Hawaiian      Other Pacific Islander      Other      Refuse to report

Ethnicity: Please circle one of the following

- Hispanic or Latin      Non Hispanic      Refuse to report

Language: Please circle one of the following

- English      Spanish      Russian      Indian-including Hindi&Tamil      Other

Email address \_\_\_\_\_

### Authorization for Release of Information

I hereby authorize Terre Haute Internal Medicine to release information requested by my insurance carrier and/or Workers' Compensation carrier. Additionally, I authorize the release and or obtain information regarding my Rx history from any external sources such as hospitals, Physicians, Pharmacies and etc.

### Authorization to send Information to Pharmacy

I hereby authorize Dr. Pardeep Kumar, MD and/or Dr. Tejaswini Kumar, MD to send any confidential information to the pharmacy of my choosing.

### Authorization to Obtain Information From Pharmacy

I hereby authorize Dr. Pardeep Kumar, MD and/or Dr. Tejaswini Kumar, MD to obtain and view my prescription history from external sources.

### Authorization for Treatment

I hereby authorize Dr. Pardeep Kumar, MD or Dr. Tejaswini Kumar, MD to treat me for any medical issues

### Assignment of Benefits

I hereby authorize assignment and payment be made directly to Terre Haute Internal Medicine of any medical benefits and/or Medicare assignment. I understand that insurance may not and the Medicare does not pay 100% of the medical charges.

I hereby acknowledge and agree to pay any and all charges that exceed or that are not covered by insurance, including any deductible, co-pays and co-insurances. I am aware that all co-pays are due at the time of service, unless prior arrangements have been made. I am aware that if I do not have insurance that services are to be paid at the time of service.

### Collections

I hereby acknowledge that I am responsible for reasonable interest, collection fees, attorney fees of 38% or \$300.00 added to the outstanding balance, and/or court cost incurred in connection with any attempt to collect amounts I may owe. I am aware that my account will become inactive due to non compliance of payment on my account and no services will be provided until debt has been paid in full.

### Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge I have received a copy of Terre Haute Internal Medicine Associates Notice of Privacy Practice

Signature \_\_\_\_\_

Date \_\_\_\_\_