Piedmont HEALTHCARE

Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ **Sex:** ❑ Male ❑ Female

Date of birth _____ Social security number _____ Race _____ Preferred language _____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Marital status:** ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Email: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number:** _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ❑ Same as patient

Full legal name (First, Middle, Last, suffix) _____ Date of birth _____ Social security number _____

Relation to patient: ❑ Self ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____ **Sex:** ❑ Male ❑ Female

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Complete mailing address – if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer phone number:** _____

Employer complete address: _____
(Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): _____

Relation to patient: ❑ Spouse ❑ Mother ❑ Father ❑ Legal guardian ❑ Other: _____

Home phone number: _____ **Cell phone number:** _____ **Work number:** _____

Complete mailing address – if different from patient: _____

INSURANCE INFORMATION ❑ Self-pay (no insurance)

Primary insurance: _____ **Patient relation to subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Secondary insurance: _____ **Patient relation to subscriber:** ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Prescription/Rx provider: _____ **(if different from insurance carrier)**

Full name of subscriber: _____ **(complete below if different from patient, spouse or guarantor)**

Subscriber date of birth: _____

Employment status: ❑ Full-time ❑ Part-time ❑ Active duty ❑ Self-employed ❑ Not employed ❑ Retirement date: _____

Employer name: _____ **Employer size:** ❑ 0 – 19 employees ❑ 20 – 99 ❑ 100+

Employer complete address: _____
(Street, city, state, zip code)

Primary care physician:	**Do you want anyone to know you are here?** ❑ **Yes or** ❑ **No**

DO NOT SCAN

PIEDMONT PHYSICIANS SURGICAL SPECIALISTS
HISTORY AND PHYSICAL FORM

DATE_____ NAME_____ BIRTHDATE_____

PRIMARY CARE PHYSICIAN_____ REFERRING PHYSICIAN_____

*Reason for Office Appointment today: _____

SOCIAL HISTORY Occupation: _____ Marital Status: S M W D

TOBACCO USE ☐ Never

☐ Current Smoker – Packs/day: ☐ ¼ pack ☐ ½ pack ☐ ¾ pack ☐ 1pack ☐ 1½ packs ☐ 2packs ☐ Other: _____

Number of years: _____ ☐ Cigarettes / ☐ Pipe / ☐ Cigars / ☐ E- Cigarettes / ☐ Vapor

☐ Former Smoker - Date/Year quit _____

☐ Dip Snuff / ☐ Chew Tobacco - Number of years: _____ Date/Year quit: _____

ALCOHOL USE ☐ Never

☐ Wine- Glasses/Week: _____ ☐ Beer- Cans/Week: _____ ☐ Liquor- Shots/Week: _____ ☐ Other: _____

DRUG/SUBSTANCE USE ☐ Never

☐ IV ☐ Other- see comments ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Amphetamines ☐ Barbituates
☐ Benzodiazepines ☐ "Crack" Cocaine ☐ Codeine ☐ Fentanyl ☐ Flunitrazepam ☐ GHB ☐ Hashish ☐ Heroin
☐ Hydrocodone ☐ Hydromorphone ☐ Ketamine ☐ LSO ☐ MDMA (Ecstacy) ☐ Mescaline ☐ Methaqualone
☐ Methylphenidate ☐ Morphine ☐ Nitrous Oxide ☐ Opium ☐ Oxycodone ☐ PCP ☐ Psilocybin ☐ Solvent Inhalants

Use/Week: _____

ALLERGIES ☐ NO KNOWN ALLERGIES

Medication or Food Name	Low/Medium/High	Type of Reaction	Year Noted
1.			
2.			
3.			
4.			
5.			
☐ Iodine ☐ Shellfish ☐ X-Ray Dye ☐ Latex			

PHARMACY NAME: _____ PHONE #: _____ LOCATION: _____

CURRENT MEDICATIONS *List prescription drugs, over the counter meds, vitamins, herbal remedies & diet drugs* ☐ NONE

Medication Name	Strength (mg)	How Much Do You Take?	How Often Per Day?
Example: Aspirin	*81mg*	*One Tablet*	*Daily*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

PIEDMONT PHYSICIANS SURGICAL SPECIALISTS-
HISTORY AND PHYSICAL FORM

DATE_____ NAME_____ BIRTHDATE_____

PAST MEDICAL HISTORY **Please check if you have a HISTORY of the following** ☐ NONE

- ☐ AIDS
- ☐ Allergies_____
- ☐ Anemia
- ☐ Aneurysm- ☐ Abdominal ☐ Thoracic
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autism
- ☐ Benign Breast- ☐ Cyst ☐ Mass ☐ Left ☐ Right
- ☐ Benign Prostate Hyperplasia (BPH)
- ☐ Bipolar Disorder
- ☐ Blood Transfusion
- ☐ Blindness
- ☐ Cancer- ☐ Breast ☐ Cervical ☐ Colon ☐ Kidney ☐ Leukemia ☐ Lung ☐ Lymphoma ☐ Myeloma ☐ Oral ☐ Ovarian ☐ Rectal ☐ Stomach ☐ Testicular ☐ Thyroid ☐ Uterine ☐ Other_____
- ☐ Cardiac Arrhythmia (Irregular Heart Beat)
- ☐ Cataracts- ☐ Left ☐ Right
- ☐ CHF (Congested Heart Failure)
- ☐ Clotting Disorder (Coagulopathy)
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus- Insulin Dependent
- ☐ Diabetes Mellitus- Non-Insulin Dependent
- ☐ Disc Disease
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Down Syndrome
- ☐ DVT (Deep Vein Thrombosis)
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Erectile Dysfunction
- ☐ Fractures_____
- ☐ GERD (Reflux)
- ☐ GI Ulcers (Peptic Ulcer Disease)
- ☐ Glaucoma- ☐ Left ☐ Right
- ☐ Gout
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Hemorrhoids
- ☐ Hepatitis- ☐ A ☐ B ☐ C
- ☐ Hernia- ☐ Inguinal ☐ Incisional ☐ Umbilical
- ☐ Herniated / Bulging Disc
- ☐ Hiatal Hernia
- ☐ HIV
- ☐ Hypercalcemia (Elevated Calcium)
- ☐ Hyperlipidemia (Elevated Cholesterol)
- ☐ Hyperparathyroidism (Overactive)
- ☐ Hypertension (High Blood Pressure)
- ☐ Irritable Bowel Disease
- ☐ Kidney Disease
- ☐ Kidney Failure- ☐ Hemodialysis ☐ Peritoneal Dialysis
- ☐ Kidney Stone
- ☐ Liver Disease
- ☐ Lupus
- ☐ Meningitis
- ☐ Menopause (Age or Year) _____
- ☐ Mitral Valve Prolapse
- ☐ Multiple Sclerosis
- ☐ MRSA
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Nerve / Muscle Disease
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Ovarian Cyst
- ☐ Pacemaker / Defibrillator
- ☐ Pancreatitis
- ☐ Paralysis- Hemiplegia- ☐ Left ☐ Right
- ☐ Paralysis- Paraplegia- Legs/Lower body
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Peripheral Vascular Disease (PVD)
- ☐ Pleural Effusion- ☐ Left ☐ Right
- ☐ Pneumonia
- ☐ Pneumothorax (Collapsed Lung) ☐ Left ☐ Right
- ☐ Polio
- ☐ Positive PPD (TB Test)
- ☐ Post-Traumatic Stress Syndrome
- ☐ Prostate Disease
- ☐ Psoriasis
- ☐ Pulmonary Embolism (Blood Clot Lung) ☐ Left ☐ Right
- ☐ Restless Leg Syndrome
- ☐ Rheumatic Fever
- ☐ Schizophrenia
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Anemia
- ☐ Skin Ulcers- Location_____
- ☐ Sleep Apnea- - ☐ CPAP ☐ BPAP
- ☐ Stents- ☐ Heart ☐ Leg Date_____
- ☐ Stroke (CVA)- Date_____
- ☐ Substance Abuse
- ☐ Supplemental Oxygen Use
- ☐ Syncope (Fainting)
- ☐ Thrombocytopenia (Low Platelets)
- ☐ Thyroid Disease – ☐ Hypo (Low) ☐ Hyper (High)
- ☐ Thyroid Goiter
- ☐ TIA (Mini Stroke)
- ☐ Tuberculosis
- ☐ Undescended Testicle
- ☐ Wears- ☐ Glasses ☐ Contacts
- ☐ Wears Hearing Aid- ☐ Left ☐ Right
- ☐ Wears- ☐ Partial- ☐ Upper ☐ Lower ☐ Dentures- ☐ Upper ☐ Lower

PIEDMONT PHYSICIANS SURGICAL SPECIALISTS-
HISTORY AND PHYSICAL FORM

DATE_____ NAME_____ BIRTHDATE_____

REVIEW OF SYSTEMS **Please check if you CURRENTLY have the following** ☐ NONE

CONSTITIONAL
- ☐ Activity Change
- ☐ Appetite Change
- ☐ Chills ☐ Fever
- ☐ Diaphoresis (Sweats)
- ☐ Fatigue
- ☐ Unexpected Weight Change

HENT
- ☐ Congestion
- ☐ Dental Problem
- ☐ Drooling
- ☐ Ear Discharge ☐ Ear pain
- ☐ Facial Swelling
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Nosebleeds
- ☐ Postnasal Drip
- ☐ Rhinorrhea (Runny Nose)
- ☐ Sinus Pressure
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Tinnitus (Ringing in Ears)
- ☐ Trouble Swallowing
- ☐ Voice Change

EYES
- ☐ Eye Discharge ☐ Eye Itching
- ☐ Eye Pain ☐ Eye Redness
- ☐ Photophobia (Sensitivity to light)
- ☐ Visual Disturbance

RESPIRATORY
- ☐ Sleep Apnea
- ☐ Chest Tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Stridor (Harsh sounding breathing)
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Bradycardia (Slow heart rate)
- ☐ Chest Pain
- ☐ Leg Swelling- ☐ Left ☐ Right ☐ Both
- ☐ Palpitations
- ☐ Tachycardia (Fast heart rate)
- ☐ Varicose Veins- ☐ Left ☐ Right ☐ Both

GASTRO-INTESTINAL / RECTAL
- ☐ Abdominal Bulge / Swelling
- ☐ Abdominal Distention
- ☐ Abdominal Mass
- ☐ Abdominal Pain
- ☐ Anal / Rectal Bleeding
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Nausea ☐ Vomiting
- ☐ Rectal Pain
- ☐ Rectal Tear (Fissure)

ENDOCRINE
- ☐ Cold or ☐ Heat - Intolerance
- ☐ Polydipsia (Excessive Thirst)
- ☐ Polyphagia (Excessive Hunger)
- ☐ Polyuria (Excessive Urination)

GENITOURINARY
- ☐ Difficulty Urinating
- ☐ Dysuria (Painful urination)
- ☐ Enuresis (Urinary Incontinence)
- ☐ Flank Pain
- ☐ Frequency
- ☐ Hematuria (Blood in urine)
- ☐ Nocturia (Urination during the night)
  ☐ 1-2 times ☐ 3-4 times ☐ 5+ times
- ☐ Pelvic Pain- ☐ Left ☐ Right
- ☐ Pregnant- Currently– # Weeks_____
- ☐ Urgency
- ☐ Urine Decreased
- ☐ Vaginal Bleeding
- ☐ Vaginal Discharge
- ☐ Vaginal Pain

MUSCULAR SKELETAL
- ☐ Arthralgia (Joint pain)
- ☐ Back Pain
- ☐ Gait Problem
- ☐ Joint Swelling
- ☐ Swelling- ☐ Arm ☐ Hand ☐ Leg ☐ Foot
  ☐ Left ☐ Right ☐ Both
- ☐ Myalgia (Muscle pain)
- ☐ Neck Pain
- ☐ Neck Stiffness
- ☐ Leg Pain- ☐ Left ☐ Right ☐ Both
  - ☐ Walking – Distance_____
  - ☐ Standing or Sitting
  - ☐ Calf Pain
  - ☐ Uphill or Hurried Walking
  - ☐ Ordinary Pace on Level Surface
  - ☐ Pain Disappears While Still Walking

  Do you: ☐ Stop ☐ Slow Down ☐ Continue
  ☐ Pain Disappears < 10 Minutes
  ☐ Pain Last > 10 Minutes with Standing Still
- ☐ Cold Extremities- ☐ Arm ☐ Hand ☐ Leg ☐ Foot
  ☐ Left ☐ Right ☐ Both

SKIN
- ☐ Change color- ☐ Arm ☐ Hand ☐ Leg ☐ Foot
  ☐ Left ☐ Right ☐ Both
- ☐ Pale Color
- ☐ Rash
- ☐ Wound / Ulcers _____
  ☐ Left ☐ Right ☐ Both
- ☐ Nodule / Mass_____

ALLERGY / IMMUNOLOGY
- ☐ Environmental Allergies
- ☐ Food Allergies
- ☐ Immunocompromised

NEUROLOGIC
- ☐ Dizziness
- ☐ Facial Asymmetry
- ☐ Headaches
- ☐ Light-Headedness
- ☐ Numbness- ☐ Arm ☐ Hand ☐ Leg ☐ Foot
  ☐ Left ☐ Right ☐ Both
- ☐ Seizures
- ☐ Speech Difficulty
- ☐ Syncope (Fainting)
- ☐ Tremors
- ☐ Weakness- ☐ Arm ☐ Leg
  ☐ Left ☐ Right ☐ Both

HEMATOLOGIC
- ☐ Adenopathy (Enlarged Lymph Nodes)
- ☐ Bruises/ Bleeds Easily

PSYCHIATRIC
- ☐ Agitation
- ☐ Behavioral Change
- ☐ Confusion
- ☐ Decreased Concentration
- ☐ Dysphoric Mood (Unease/General Dissatisfaction w/ Life)
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous / Anxious
- ☐ Self- Injury
- ☐ Sleep Disturbances
- ☐ Suicidal Ideas

BREASTS
- ☐ Nipple Discharge ☐ Left ☐ Right
- ☐ Nipple Inversion ☐ Left ☐ Right
- ☐ Breast Lump ☐ Left ☐ Right
- ☐ Breast Pain ☐ Left ☐ Right
- ☐ Breast Implants ☐ Left ☐ Right ☐ Both
- ☐ Swollen Glands Under Arm ☐ Left ☐ Right
- ☐ Abnormal Mammogram
  When/Where_____
- ☐ Hormone Therapy- ☐ Past ☐ Present

PIEDMONT PHYSICIANS SURGICAL SPECIALISTS
HISTORY AND PHYSICAL FORM

DATE_____ NAME_____ BIRTHDATE_____

PAST SURGICAL HISTORY Please be specific with type of surgery ☐ NONE

Surgery	Date	Surgery	Date
1.		11.	
2.		12.	
3.		13.	
4.		14.	
5.		15.	
6.		16.	
7.		17.	
8.		18.	
9.		19.	
10.		20.	

FAMILY MEDICAL HISTORY ☐ ADOPTED ☐ UNKNOWN ☐ NONE

Family Members	Major Medical Problems	If Deceased, Causes	Age at Death
Mother			
Father			
Sister			
Brother			
Daughter			
Son			
Maternal Aunt			
Maternal Uncle			
Paternal Aunt			
Paternal Uncle			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Piedmont HEALTHCARE

Privacy Questionnaire

Patient Full Name:_____ DOB:_____

Current Address:_____

Please review and answer the following questions in regards to your protected health information.

The contact information and phone numbers you provide will be used as agreed to below. Please note that the information will be in effect for both Piedmont Physicians and Piedmont Heart Institute locations as applicable.

1. ❑ I give permission to leave a detailed message regarding my healthcare on the phone number provided below:

   Phone number:_____

   Phone number:_____

   ❑ No please only leave a callback name and number when you attempt to reach me.

2. I give permission to discuss my medical information with the following individuals:

   - Name:_____ Relationship:_____
   - Name:_____ Relationship:_____
   - Name:_____ Relationship:_____
   - Name:_____ Relationship:_____

Authorization Signatures:

Your signature below further indicates your understanding that this authorization will be valid for a period of one year from today's date and will expire at that time unless another form is completed. You may revoke or request changes to this authorization at any time by completing a new Privacy Questionnaire.

Patient/Legal Representative Signature	Patient/Legal Representative Name (**PRINT**)	Date	Time

Relationship to Patient	Reason Patient is unable to sign

Piedmont HEALTHCARE

Patient Financial Agreement and Responsibilities

Patient Label

Piedmont Healthcare is committed to providing patients with information regarding their coverage and financial responsibilities. In consideration of services provided by Piedmont Healthcare (PHC), the Patient or undersigned representative acting on behalf of the Patient agrees to the following:

1. Emergency and Labor Services

Patient understands his/her right to receive an appropriate medical screening exam performed by a doctor or other qualified medical professional to determine whether Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of the PHC staff and facilities, even if Patient cannot pay for these services, does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

2. Non-Medicare Patient Responsibility for Payment

In return for **Medical Treatment/Services** rendered to the Patient or any infant(s) born to the Patient, Patient understands and unconditionally agrees to the following:

- Patient agrees to pay all co-payments, deductibles or co-insurances.
- Patient understands and agrees that he/she will be charged the PHC standard charge master rates for all services not covered by a Payor or that are self-pay.
- Patient understands that he/she may qualify for financial assistance. For more information, the patient may contact a local financial counseling resource, call the PHC Customer Service Center (1-855-788-1212), online at www.piedmont.org or via email at assistance@piedmont.org.
- Patient specifically agrees to pay for any services, which are determined not to be covered by any health benefit plan or insurance company.
- Patient is aware that he/she is not relieved of liability by any extension of time granted for the payment of these charges, not by the acceptance by the PHC of a note of the patient or any third person.
- If PHC requires legal assistance to collect an account, Patient agrees to pay the cost incurred for such collections.
- PHC may use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options and by this authorization expressly permit sources and employers to provide PHC with all information requested.

3. Assignment of Insurance or Health Plan Benefits

Patient acknowledges the assignment and authorization for direct payment to PHC for all insurance and health plan benefits and settlements whether hospital, medical or liability insurance including but not limited to, the proceeds of any settlement or judgment of any third party claim as payment for any and all services performed at a PHC entity. Patient agrees that the insurance company's or health plan's payment to PHC pursuant to this authorization shall discharge the insurance company's or health plan's obligations to the extent of such payment.

4. Filing of Third Party Claims

Patient acknowledges that upon proof of coverage PHC will submit a claim for payment of insurance benefits and accept payments from third party payors ("Payors") to be credited to Patient's account as they are received. Patient agrees that the filing of insurance claims is performed as a service and in no way relieves Patient of the obligation to pay in full. Additionally the Patient acknowledges the following:

- Patient is responsible to follow up with any insurance company or employer within 30 days to see that Patient's bill is paid promptly.
- Patient understands that he/she is financially responsible for charges not paid according to this agreement. If Patient overpays the amount owed on his/her account, Patient assigns credit to be applied to any other existing unpaid accounts ("Other Accounts") for which the Patient or the insured or guarantor is also responsible. Any money remaining after the Patient's account and Other Accounts have been paid in full will be refunded to the patient or guarantor.
- Insurance companies will often deny claims when the insurance is not presented at the time of service. Please contact our Customer Solution Center with your Insurance/Payor information at 1-855-788-1212. Otherwise your account may be considered self-pay/uninsured and you will be responsible for the total bill.

5. Assignment of Medicare Benefits

Patient certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. Patient requests that the payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by PHC and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes PHC and Healthcare Professionals to submit claims to Medicare for payment. Patient authorizes any holder of medical or other information to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Patient understands he/she is responsible for any deductibles, co-payments and/or non-covered services as defined by Medicare to be paid in accordance with all terms and conditions specified herein.

6. Assignment of Medicaid Benefits

Patient certifies that the information given in applying for payment under Title XIX of the Social Security Act is correct. Patient authorizes any holder of medical or other information to release to the Social Security Administration or its intermediaries or carriers any and all information needed for this or related Medicaid claims. Patient requests payment of authorized benefits be made on Patient's behalf to the provider of Medical Treatment/Services. Patient assigns the benefits payable for Medical Treatment/Services rendered by PHC and all Healthcare Professionals rendering care and/or treatment to Patient and authorizes PHC and Healthcare Professionals to submit claims to Medicaid for payment.

7. Authorization to Release Information

PHC is authorized to release information contained in the patient record. The information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information. PHC, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. Reasons for releasing a Patient's record include, but are not limited to, insurance company(s), their agents or other third party payor and/or government or social service agencies which may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of PHC, as mandated by law, or to alternate care providers, including community agencies and services, as ordered by Patient's physician or as requested by Patient or Patient's family for post-hospital care. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL PHC AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-PHC AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.** Patient also agrees, in order for PHC to service accounts or to collect liabilities owed, to receive contact by telephone at any telephone number associated with their record, including wireless telephone numbers, which could result in charges to Patient. PHC or its agents may also contact Patient by sending text messages or emails, using any email address Patient provides. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

8. Consent Timeframe and Applicability

The above agreements are applicable to all inpatient or outpatient hospital-based services and all ambulatory or physician office-based services and are valid for a term of one (1) year from the date of signature below. The same *agreement* applies to delivered infant(s) while a patient of PHC.

Validity of Form

Patient acknowledges that a copy or an electronic version of this document may be used in place of and is as valid as the original. **The patient confirms that he/she has read and understood and accepted the terms of this document and he/she is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.**

Patient/Patient Representative Signature	Patient Name (**PRINT**)	Date	Time
Relationship to Patient	Reason Patient is unable to sign		
Piedmont Healthcare Representative Signature	Piedmont Healthcare Representative Name (**PRINT**)	Date	Time

Piedmont HEALTHCARE

Conditions of Service and Consent for Treatment

Patient Label

IMPORTANT: DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

In consideration of services provided by Piedmont Healthcare (PHC), the Patient or undersigned representative acting on behalf of the Patient agrees and consents to the following:

1. Consent to Routine Medical Treatment/Services

Patient consents to the rendering of Medical Treatment/Services as considered necessary and appropriate by the attending physician or other practitioner, a member of the PHC medical staff who has requested care and treatment of Patient, and others with staff privileges at PHC. Medical Treatment/Services may be performed by "Healthcare Professionals" (physicians, nurses, technologists, technicians, physician assistants or other healthcare professionals). Patient authorizes the attending or other practitioner, the medical staff of PHC and PHC to provide Medical Treatment/Services ordered or requested by attending or other practitioner and those acting in his or her place. **The consent to receive "Medical Treatment/Services" includes, but is not limited to: hospital care; examinations (x-ray or otherwise); laboratory procedures; medications; infusions; transfusions of blood and blood products; drugs; supplies; anesthesia; surgical procedures and medical treatments; radiation therapy; recording/filming for internal purposes (i.e., identification, diagnosis, treatment, performance improvement, education, safety, security) and other services which Patient may receive.** In the event PHC determines that Patient should provide blood specimens for testing purposes in the interest of the safety of those with whom Patient may come in contact; Patient consents to the withdrawing and testing of Patient's blood and to the release of test information where this is deemed appropriate for the safety of others.

2. Legal Relationship between Hospital and Physician

Some of the health care professionals performing services at PHC hospitals are independent contractors and are not PHC agents or employees. Independent contractors are responsible for their own actions and PHC shall not be liable for the acts or omissions of any such independent contractors.

3. Explanation of Risk and Treatment Alternatives

Patient acknowledges that the practice of medicine is not an exact science and that **NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO THE PATIENT** concerning the outcome and/or result of any **Medical Treatment/Services**. While routinely performed without incident, there may be material risks associated with each of these **Medical Treatment/Services**. Patient understands that it is not possible to list every risk for every **Medical Treatment/Services** and that this form only attempts to identify the most common material risks and the alternatives (if any) associated with the **Medical Treatment/Services**. Patient also understands that various Healthcare Professionals may have differing opinions as to what constitutes material risks and alternative **Medical Treatment/Services.** ***By signing this form***:

Patient consents to Healthcare Professionals performing **Medical Treatment/Services** as they may deem reasonably necessary or desirable in the exercise of their professional judgment, **including those Medical Treatment/Services that may be unforeseen or not known to be needed at the time this consent is obtained;** and Patient acknowledges that Patient has been informed in general terms of the nature and purpose of the **Medical Treatment/Services**; the material risks of the **Medical Treatment/Services** and practical alternatives to the **Medical Treatment/Services**.

The **Medical Treatment/Services** may include, but are not limited to the following:

a). **Needle Sticks,** such as shots, injections, intravenous lines or intravenous injections (IVs). The material risks associated with these types of Procedures include, but are not limited to, nerve damage, infection, infiltration (which is fluid leakage into surrounding tissue), disfiguring scar, loss of limb function, paralysis or partial paralysis or death. Alternatives to Needle Sticks (if available) include oral, rectal, nasal or topical medications (each of which may be less effective).

b). **Physical Tests, Assessments and Treatments** such as vital signs, internal body examinations, wound cleansing, wound dressing, range of motion checks and other similar procedures. The material risks associated with these types of Procedures include, but are not limited to, allergic reactions, infection, severe loss of blood, muscular-skeletal or internal injuries, nerve damage, loss of limb function, paralysis or partial paralysis, disfiguring scar, worsening of the condition and death. Apart from using modified Procedures, no practical alternatives exist.

c). **Administration of Medications** via appropriate route whether orally, rectally, topically or through Patient's eyes, ears or nostrils, etc. The material risks associated with these types of Procedures include, but are not limited to, perforation, puncture, infection, allergic reaction, brain damage or death. Apart from varying the method of administration, no practical alternatives exist.

d). **Drawing Blood, Bodily Fluids or Tissue Samples** such as that done for laboratory testing and analysis. The material risks associated with this type of Procedure include, but are not limited to, paralysis or partial paralysis, nerve damage, infection, bleeding and loss of limb function. Apart from long-term observation, no practical alternatives exist.

e). **Insertion of Internal Tubes** such as bladder catheterizations, nasogastric tubes, rectal tubes, drainage tubes, enemas, etc. The material risks associated with these types of Procedures include, but are not limited to, internal injuries, bleeding, infection, allergic reaction, loss of bladder control and/or difficulty urinating after catheter removal. Apart from external collection devices, no practical alternatives exist.

f). **Radiological Studies** such as X-rays, CT scans or MRI scans. The material risks associated with these types of Procedures include, but are not limited to, radiation exposure.

If Patient has any questions or concerns regarding these **Medical Treatment/Services**, Patient will ask Patient's attending provider to provide Patient with additional information. Patient also understands that Patient's attending or other provider may ask Patient to sign additional informed consent documents concerning these or other **Medical Treatment/Services**.

4. Emergency and Labor Services

Patient understands Patient's right to receive an appropriate medical screening exam performed by a doctor, or other qualified medical professional, to determine whether Patient is suffering from an emergency medical condition, and if such a condition exists, stabilizing treatment within the capabilities of the PHC's staff and facilities, even if Patient cannot pay for these services, does not have medical insurance or Patient is not entitled to Medicare or Medicaid.

5. Healthcare Practitioners in Training

Patient recognizes that among those who may attend Patient at PHC are medical, nursing and other health care personnel who are in training and who, unless specifically requested otherwise, may be present and participate in patient care activities as part of their medical education. There also may be present from time to time a medical product or medical device representative. Consent is hereby given for the presence and participation of such persons as deemed appropriate by the attending physician.

6. Remaining in Patient Care Area and Closed Circuit Monitoring/Videotaping/Photography

Patient acknowledges and understands that, Patient is advised to remain in the patient care area at all times to optimize Patient's medical care and safety. If Patient chooses to leave the area for reasons that are not treatment related, Patient assumes any and all liability for any incident, accident, misadventure or harm, including deterioration of Patient's condition, which Patient may suffer. Patient agrees to hold PHC, all Healthcare Professionals, harmless for any injury or harm resulting from Patient's decision to leave the patient care area and Patient accepts any and all responsibility for such actions. Patient also understands that closed circuit monitoring, videotaping and photography patient care may be used for educational, clinical purposes and/or safety related purposes.

7. Authorization to Release Information

PHC is authorized to release information contained in the patient record. The information authorized to be released shall include, but is not limited to, infectious or contagious disease information, including HIV or AIDS-related evaluations, diagnosis or treatment; information about drug or alcohol abuse or treatment of same and/or psychiatric or psychological information. Patient waives any privilege pertaining to such confidential information. PHC, its agents and employees are hereby released from any and all liabilities, responsibilities, damages, claims and expenses arising from the release of information as authorized above. Reasons for releasing a Patient's record include, but are not limited to, insurance company(s), their agents or other third party payor and/or government or social service agencies which may or will pay for any part of the medical/hospital expenses incurred or authorized by representatives of PHC, as mandated by law, or to alternate care providers, including community agencies and services, as ordered by Patient's physician or as requested by Patient or Patient's family for post-hospital care. **PATIENT ACKNOWLEDGES AND AGREES THAT PATIENT'S RECORDS WILL BE AVAILABLE TO ALL PHC AFFILIATED ENTITIES AND PROVIDERS, AND TO NON-PHC AFFILIATED REFERRING PROVIDERS IN COMPLIANCE WITH THE PROVISIONS OF MEANINGFUL USE.** Patient also agrees, in order for PHC to service accounts or to collect liabilities owed, to receive contact by telephone at any telephone number associated with their record, including wireless telephone numbers, which could result in charges to Patient. PHC or its agents may also contact Patient by sending text messages or emails, using any email address Patient provides. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

8. Patient Survey

Patient authorizes PHC and/or its authorized representative to contact Patient after discharge for the purpose of conducting patient satisfaction surveys and other studies.

9. Patient Rights and Personal Valuables

Patient acknowledges that Patient has received a copy of Patient Rights and has verified the information utilized during this registration and confirms its accuracy. PHC shall not be liable for the loss or damage of any personal belongings, including but not limited to money, cell phones, laptops, electronic devices, jewelry, hearing aids, computers or dentures, unless properly secured and placed within the hospital safe.

10. Consent Timeframe and Applicability

The above consents are applicable to all inpatient and outpatient hospital-based services, as well as all ambulatory and physician office based services. With respect to inpatient hospital based services, including infants delivered at any PHC affiliate, the consents shall be valid for a period of 30 days from the date of signature below or for the period of time Patient is confined in the hospital for a particular purpose, whichever is greater. For outpatient-based hospital services, the above consents are valid for a period of 30 days from the date of signature below; provided, however, that if outpatient hospital-based services are provided through serial visits, the above consents will be valid for a term of one (1) year from the date of signature below. For all ambulatory or physician office based services, the above consents are valid for a period of one (1) year from the date of signature below.

Validity of Form

Patient acknowledges that a copy, or an electronic version of this document may be used in place of and is as valid as the original.

Patient understands that the Healthcare Professionals participating in the Patient's care will rely on Patient's documented medical history, as well as other information obtained from Patient, Patient's family or others having knowledge about Patient, in determining whether to perform or recommend the Procedures; therefore, Patient agrees to provide accurate and complete information about Patient's medical history and conditions.

Patient confirms that Patient has read and understood and accepted the terms of this document and the undersigned is the Patient, the Patient's legal representative or is duly authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

Patient/Patient Representative Signature	Patient Name (**PRINT**)	Date	Time

Relationship to Patient	Reason Patient is unable to sign

Piedmont Healthcare Representative Signature	Piedmont Healthcare Representative Name (**PRINT**)	Date	Time

Piedmont HEALTHCARE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Piedmont Healthcare, Inc. and its affiliates, including its Hospitals, Clinics, Employed Physicians, our foundations and other facilities ("Piedmont Providers") are all committed to keeping your health information private. We are required by the federal Privacy Rule to protect your medical information (called "protected health information" or "PHI") and to provide you with this Notice of Privacy Practices (the"Notice") describing our legal duties and privacy practices. Piedmont Healthcare professionals, employees, students, volunteers and business associates are all required to follow our privacy practices in caring for our patients. In certain circumstances, pursuant to this Notice, patient authorization or applicable laws and regulations, PHI can be used by Piedmont Providers or disclosed to other parties as described below.

Uses and Disclosures for Treatment, Payment and Health Care Operations: Piedmont Providers may use or disclose your PHI for the purposes of treatment, payment and health care operations, described in more detail below, without obtaining written authorization from you.

For Treatment: Piedmont Providers may use and disclose PHI in the course of providing, coordinating or managing your medical treatment, including the disclosure of PHI for treatment activities of another health care provider. For example, if you are being treated by a primary care physician, that physician may need to use/disclose PHI to a specialist physician whom he or she consults regarding your condition, or to a nurse who is assisting in your care.

For Payment: Piedmont Providers may use and disclose PHI in order to bill and collect payment for the health care services provided to you. For example, a Piedmont Provider may need to give PHI to your health plan in order to be reimbursed for the services provided to you. We may also disclose PHI to our business associates, such as billing companies, and claims processing companies.

For Health Care Operations: Piedmont Providers may use and disclose PHI as part of their operations, including for quality assessment and improvement, such as evaluating the treatment and services you receive and the performance of our staff in caring for you. Other activities include training, learning purposes, compliance and risk management activities, planning and development and administration.

For Medical Research: Research is vital to the advancement of medical science. Federal regulations permit use of PHI in medical research, either with your authorization or without your authorization when the research study is reviewed and approved by an Institutional Review Board or privacy board before any study begins, or for reviews preparatory to research as permitted by law, or for research on decedent's information as permitted by law.

As Required by Law and Law Enforcement: Piedmont Providers may use or disclose your PHI when required by law without your authorization. We may also disclose PHI when ordered to in a judicial or administrative proceeding, in response to subpoenas or discovery requests, to identify or locate a suspect, fugitive, material witness or missing person, when dealing with gunshot and other wounds, about criminal conduct, to report a crime, its location or victims, or the identity, description or location of a person who committed a crime or for other law enforcement purposes.

For Public Health Activity: Piedmont Providers may disclose PHI to government officials in charge of collecting information about births and deaths, preventing and controlling disease, reports of child abuse or neglect and of other victims of abuse, neglect or domestic violence, reactions to medications or product defects or problems, or to notify a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities: Piedmont Providers may use or disclose certain information to the government for authorized oversight activities including inspections, audits, licensure and other investigations of our providers or related matters.

Organ, Eye and Tissue Donation: Piedmont Providers may release PHI to organ procurement organizations to facilitate organ, eye and tissue donation and transplantation.

Coroners, Medical Examiners, Funeral Directors and Individuals Involved in Your Health Care or Payment for Your Health Care: Piedmont Providers may disclose PHI to coroners, medical examiners and funeral directors for the purpose of identifying a decedent, determining a cause of death or otherwise as necessary to enable these parties to carry out their duties consistent with applicable law.

Uses and Disclosures for Involvement in Your Care: Unless you object, Piedmont Providers may disclose your PHI to a family member, other relative, friend or other person you identify as involved in your health care or payment for your health care. We may use or disclose information to family members or others involved in the care of deceased individuals. We may also notify those people about your location or condition. Upon request, PHI may be released fifty (50) years after an individual's death.

To Avoid a Serious Threat to Health or Safety or in Disaster Relief Efforts: Piedmont Providers may use and disclose PHI to law enforcement personnel or other appropriate persons, to prevent or lessen a serious threat to the health or safety of a person or the public. We may also disclose information about you to an organization assisting in disaster relief efforts so that your family can be notified about your location, condition and status. If you do not want us to disclose information for disaster relief efforts, we will not do so unless we must respond in an emergency.

Specialized Government Functions: Piedmont Providers may use and disclose certain PHI if you are military personnel or a veteran. We may also disclose PHI to authorized federal officials for intelligence, counterintelligence and other national security activities, and for the provision of protective services to the President or other authorized persons or foreign heads of state.

Workers' Compensation: Piedmont Providers may disclose PHI to comply with workers' compensation or other similar laws that provide benefits for work-related injuries or illnesses.

Fundraising Efforts: Your PHI may be used to contact you or may be disclosed for Piedmont Provider fundraising efforts. Such disclosure would be limited to demographic information, such as your name, address, other contact information such as your phone number, age, gender and date of birth, the dates you required treatment or services at a Piedmont Provider, department of service information, treating physician, outcome information and health insurance status. You have a right to opt out of receiving such fundraising communications and in the event you are contacted for fundraising, you will be given the opportunity to opt out.

Appointment Reminders, Follow-Up Care and Treatment Alternatives: We may use or disclose your information to remind you about appointments or treatment alternatives that may be useful to you.

Patient Directories: Unless you object, we may use some of your PHI to maintain a directory in our facilities. This information may include your name, your location in the facility, your general condition (e.g. fair, good, etc.) and your religious affiliation, and the information may be disclosed to members of the clergy. Except for religious affiliation, the information may be disclosed to other persons who ask for you by name.

Uses and Disclosures of PHI For Which Authorization is Required: Other types of uses and disclosures of your PHI not described in this Notice will be made only with your written authorization, which you have the limited right to revoke in writing. Piedmont Providers may not use and disclose your PHI for marketing purposes except in limited circumstances as authorized by law or unless you have given us written authorization. We will not disclose psychotherapy notes except in limited circumstances either with your written authorization or as applicable law permits. Piedmont Providers will not sell your PHI unless we have your written authorization or applicable law permits.

Your Rights Regarding Your PHI: You may request that a Piedmont Provider restrict certain uses and disclosures of your PHI. We are not required to agree to a requested restriction except we must agree to a requested restriction of disclosure regarding your PHI to a health plan for payment purposes if the following conditions are met: (1) you have paid in full in advance for the associated treatment or services, (2) disclosure is not otherwise required by law and (3) you have made this request for restriction in writing when the services are performed. Piedmont cannot terminate a requested restriction of disclosure regarding your PHI to a health plan for payment purposes.

Confidential Communications: You may request that we communicate with you in a certain manner. For instance, you may request that we send you follow-up information at your home address instead of using your work address. We will accommodate reasonable requests regarding confidential communications as requested.

Right to Access Records: Generally, you have the right to inspect and copy the designated health information maintained by Piedmont about you. We require that you make a written request to the medical records department for your Piedmont Provider. We will provide you access in the format requested, if we can readily do so. For instance, you can request a paper copy of your records. If you ask for an electronic copy of your records, we will provide an electronic copy in the format you request if possible. If we cannot provide the records in the particular format, we will contact you to find another reasonable method. Within thirty (30) days of your written request for access, unless extended by an additional thirty (30) days, Piedmont will inform you of the extent to which your request is granted. In some cases, the Piedmont Provider may prepare a summary of the required medical information, if you inform us of your preference and agree in advance to a preparation fee for the summary. If you want a copy of your records, we may charge you a reasonable fee to cover copying, postage or other reasonable expenses with preparing a paper or electronic record or summary for you. If the Piedmont Provider denies you access to your record, we will provide you with the basis for the denial and your opportunity to have that denial reviewed by a licensed health care professional who was not involved in the initial decision review the denial. If the Piedmont Provider does not maintain the medical information that you request and we know where that information is, we will let you know where to redirect your request for access.

Right to Request Amendment: If you believe that your PHI maintained by a Piedmont Provider contains an error, you have the right to request that the entity correct or supplement your PHI. You must send a written request to the Director of Medical Records for the Piedmont Provider to explain why you want to amend your record. Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Piedmont Provider will inform you of the extent to which your request has or has not been granted. Piedmont Providers generally can deny your request if your request relates to PHI: (i) not created by the entity; (ii) that is not part of the records the entity maintains; (iii) that is not subject to being inspected by you; or (iv) that is accurate and complete. If your request is denied, the Piedmont Provider will give you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial; (ii) if you do not file a statement of disagreement, submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the entity's denial attached; and (iii) complain about the denial.

Right to Accounting of Disclosures: You generally have the right to request and receive a list of disclosures of your PHI a Piedmont Provider has made during the six (6) years prior to your request (but not before April 14, 2003). The list will not include disclosures (i) for which you have provided a written authorization; (ii) for treatment, payment and health care operations; (iii) made to you; (iv) for a Piedmont Provider's patient directory or to persons involved in your health care; (v) for national security or intelligence purposes; (vi) to correctional institutions or law enforcement officials; or (vii) of a limited data set. You should submit any such request to the Privacy Officer, and within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Piedmont Provider will respond to you regarding the status of your request. The entity will provide the list to you at no charge, but if you make more than one request in a year you will be charged a fee of $25.00 for each additional request.

Breach Notification: We are required to notify affected individuals in the event there is a breach of unsecured protected health information.

Notice of Privacy Practices Copy: You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. You can review and print a copy of this Notice at any Piedmont Healthcare Web site via www.piedmont.org or you may request a paper copy of this notice by contacting the Privacy Officer as described below. Please note that Piedmont, as a covered entity under the federal Privacy Rule is required to abide by the terms of the Notice in effect; however, Piedmont may revise this Notice in accordance with the law and make any changes applicable for all protected health information that Piedmont maintains. If you believe your privacy rights with respect to your PHI have been violated you have the right to contact the Privacy Officer and submit a written complaint. Piedmont Providers will not penalize you or retaliate against you for filing a complaint regarding their privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services.

If you have any questions about this notice: Please contact the Piedmont Healthcare Privacy Officer at (404) 425-7350; e-mail: privacy.officer@piedmont.org. address: 1800 Howell Mill Road, Suite 350, Atlanta, GA 30318

EFFECTIVE: March 1, 2003 REVISED: February 11, 2013 [34747P Rev. 08/13]

Piedmont HEALTHCARE

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Patient Label

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

☐ I hereby acknowledge that I have received a copy of the Piedmont Providers' "Notice of Privacy Practices."

_____
Print Name of Patient

_____ _____ _____
Signature of Patient or Patient's Authorized Representative Date Time

As the Patient's Authorized Representative, my relationship with the Patient is:_____

The Patient is unable to sign because:_____

OR

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

☐ I hereby certify that, as an employee or agent of the Piedmont Providers, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Piedmont Providers' "Notice of Privacy Practices" in accordance with the policy titled "Provision of the Notice of Privacy Practices."

_____
Print Name of Employee/Agent and Department

_____ _____ _____
Signature of Employee/Agent Date Time

Reason(s) For Not Obtaining Acknowledgment:

_____

_____

Piedmont HEALTHCARE — Authorization For Use/Disclosure of Protected Health Information

PATIENT INFORMATION

The following information is needed to assist the provider in locating the patient's records:

Patient full name:_____ Date of birth:_____

Maiden/other name:_____ Current address:_____

Patient phone # (home):_____ (work):_____ (cell):_____

REQUEST AUTHORIZATION

I hereby request and authorize Health Information Management at (choose all applicable):

☐ **Piedmont Athens Regional**	1199 Prince Avenue, Athens, GA 30606	Phone: (706) 475-3361	Fax: (706) 475-6961
☐ **Piedmont Atlanta Hospital**	1968 Peachtree Road, NW, Atlanta, GA 30309	Phone: (404) 605-3280	Fax: (404) 605-5551
☐ **Piedmont Fayette Hospital**	1255 Highway 54 West, Fayetteville, GA 30214	Phone: (770) 719-7053	Fax: (770) 719-6821
☐ **Piedmont Heart Institute**	275 Collier Road Suite 500, Atlanta, GA 30309	Phone: (404) 605-5570	Fax: (404) 355-4739
☐ **Piedmont Henry Hospital**	1133 Eagle's Landing Parkway, Stockbridge, GA 30281	Phone: (678) 604-5844	Fax: (678) 604-5076
☐ **Piedmont Medical Care Corporation**	2727 Paces Ferry Road Suite 1-1100, Atlanta, GA 30339	Phone: (678) 423-6633	Fax: (404) 609-7543
☐ **Piedmont Mountainside Hospital**	1266 Highway 515 South, Jasper, GA 30143	Phone: (706) 301-5455	Fax: (706) 301-5353
☐ **Piedmont Newnan Hospital**	745 Poplar Road, Newnan, GA 30265	Phone: (770) 400-4181	Fax: (770) 304-4218
☐ **Piedmont Newton Hospital**	5126 Hospital Drive, NE, Covington, GA 30014	Phone: (770) 385-4235	Fax: (678) 625-2068
☒ Other: Athens Regional Specialty Services	740 Prince Ave, Bldg 8A-B, Athens, GA 30606	Phone: (706) 353-1630	Fax: (706) 543-6825

_____ *(initial)*	To provide **copies** of my records checked below to: Name (*receiving person/party*):_____ Fax #:_____ Address:_____ Phone #:_____ *(required to verify Fax #)*
_____ *(initial)*	To permit **review** of my records checked below by (person's name):
_____ *(initial)*	To use/disclose PHI as described:

This authorization applies to records or PHI access from the following date or dates of service:_____

PURPOSE OF DISCLOSURE

☐ At the request of the individual (patient)
☐ For a marketing function for which a Piedmont Provider receives direct or indirect remuneration from a third party.
☐ Other:_____

DESCRIPTION OF INFORMATION TO BE RELEASED

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

☐ Entire Medical Record ☐ Emergency Room Record ☐ Pathology Slides/Blocks ☐ Financial Record
☐ Abstract of Record* ☐ Cardiac Cath Report/CD ☐ Radiology Films/CD
☐ Other – Specify:_____

*An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

AUTHORIZATION SIGNATURES

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from Health Information Management. The completed revocation must be presented to Health Information Management. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. Piedmont Providers shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today's date and **will expire at that time unless another date is written here:**_____

_____	_____	_____	_____
Patient or Legal Representative signature	**Please PRINT name**	**Today's date**	**Time**

As Legal Representative, my relationship to the patient is:_____. Any document proving such authority must be attached.

The patient is unable to sign because:_____.

NOTE: There may be fees for provision of any or all requested information. Under most circumstances, the law permits up to 30 days for record requests to be processed, however records for treatment purposes can be immediately faxed to the patient's healthcare provider when requested.