

Pinner Clinic, PA

A Rich History of Medical Tradition Since 1915

Carroll A. Pinner, III, MD Benjamin C. Pinner, MD Edwina Hallman, APRN Catherine Thomas, APRN

Welcome to Pinner Clinic! We are delighted that you have chosen us to be your primary healthcare provider. Each of our physicians and nurse practitioners are board certified in Family Medicine. We can care for you and your entire family, regardless of age or gender.

Our mission is to provide you with outstanding quality health care. To help us do this, we need certain information from you. ***Please complete the following forms (included in this patient welcome packet) and bring them with you to your first appointment:***

1. Patient Demographic Sheet
2. Compound Authorization for Release (This form allows us to release information to a family member or friend)
3. Financial Policy
4. Appointment No-Show Policy
5. Receipt of Notice of Privacy Practices
6. Pinner Clinic Patient Health Assessment
7. Pinner Clinic PCMH Questionnaire
8. HIPAA Compliant Authorization for Release of Health Information (This form allows us to request your medical records from other physicians)

In addition to the completed forms, **please bring your driver's license/photo identification, insurance cards, and all current medications, supplements, and vitamins you are taking** (bring original containers if possible). Please arrive at least 15 minutes prior to your scheduled appointment time to give our front desk staff time to meet you and process your paperwork before your scheduled appointment time.

During your first visit, you will establish a relationship with one of our physicians whom you may have designated to be your primary care physician (PCP). After your first visit, we will make every effort to schedule you with your PCP when you call for an appointment. Our nurse practitioner works very closely and under the direction of our physicians. In the event your PCP is unavailable, one of the other physicians or the nurse practitioner will be available to address your needs.

It is our goal to be available when you need us. We have time allotted every day to work in patients who are sick and need to be seen quickly. If you do not have an appointment but would like to be seen, we encourage you to use our walk-in service. Appointments are not taken for the walk-in service, and you will be seen by the first available provider. If he/she is not your regular physician, please be assured he/she will have all the necessary information and full access to your medical record in order to make excellent decisions regarding your care.

We are open from 8:00 AM to 5:00 PM Monday through Friday. Should you need care after office hours, there is always a provider on-call 24 hours a day, 7 days a week. We are also open every Saturday from 9:00 AM to Noon for urgent care needs only.

If you have any questions, please do not hesitate to call us at 803-945-7475. We are here to help. Again, welcome to Pinner Clinic. We are happy to have you as a new member of our family and can't wait to meet you!

32 River Street • Peak, South Carolina 29122
(P) 803-945-7475 • (F) 803-345-2832

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PATIENT INFORMATION

(PLEASE PRINT)

<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss	Patient's Last Name:	First:	MI:		
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	Preferred Name:	Birth/Maiden Name:			
Birth Date:	Gender:	SSN:	Email Address:		
Preferred Language:	Race:	Ethnicity:	Driver's License Number:	State:	Exp. Date:
Home phone:	Work phone:	Cell phone:			
Address:	City:	State:	ZIP Code:		
Occupation:	Employer & Address:	Employer phone:			
Referred by:	<input type="checkbox"/> Dr.	<input type="checkbox"/> Patient	<input type="checkbox"/> Other		

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill: (if self, please skip to Primary Insurance)	Is this person a patient at our practice? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Birth:	Address:	Home Phone:
Occupation:	Employer & Address:	Employer phone:

****Policy Holder's Name, SSN, Date of Birth and Relationship to Patient are REQUIRED to file all insurance claims.****

Primary Health Insurance Company:

*Policy Holder's Name: (as it appears on insurance card)	*SSN:	*Birth date:		
Group Number:	Policy Number:	Co-Payment: \$		
*Patient's relationship to Policy Holder:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

Secondary Health Insurance Company:

*Policy Holder's Name: (as it appears on insurance card)	*SSN:	*Birth date:		
Group Number:	Policy Number:	Co-Payment: \$		
*Patient's relationship to Policy Holder:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

IN CASE OF EMERGENCY (LOCAL FRIEND/ RELATIVE)

Name:	Relationship:	Phone #:	Alt. Phone #:
Name: (not living at same address)	Relationship:	Phone #:	Alt. Phone #:

The above information is true to the best of my knowledge. I authorize Pinner Clinic, P.A. or insurance company to release any information required to process my claims. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I understand payment is due at the time of service, and that Pinner Clinic reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections.

Patient/Guardian Signature: _____ Date: _____

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COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth: _____

<p>If we need to reach you during the day, what is the best daytime phone number? _____</p> <p>Is this home, work or cell? _____</p> <p>OK to leave voice mail messages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>OK to send text messages? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Check the following information that can be provided by voice mail and/or text:</p> <p><input type="checkbox"/> Financial</p> <p><input type="checkbox"/> Medical Information</p> <p><input type="checkbox"/> Results of lab tests/x-rays</p> <p><input type="checkbox"/> Appointment Information</p> <p><input type="checkbox"/> Other: _____</p>
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Pinner Clinic, PA is authorized to release protected health information regarding the above-named patient to the entities named below. The purpose of this form is to strictly adhere to patient instructions.

Person/Entity to Receive Information Provide information for each person/entity that you approve to receive your information.	Description of Information to be Released Check each that can be given to the person/entity indicated on the left
<p>Name: _____</p> <p>Best Daytime Phone: _____</p> <p>Voice mail messages ok? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Financial</p> <p><input type="checkbox"/> Medical Information</p> <p><input type="checkbox"/> Results of lab tests/x-rays</p> <p><input type="checkbox"/> Appointment information</p> <p><input type="checkbox"/> Other: _____</p>
<p>Name: _____</p> <p>Best Daytime Phone: _____</p> <p>Voice mail messages ok? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Financial</p> <p><input type="checkbox"/> Medical Information</p> <p><input type="checkbox"/> Results of lab tests/x-rays</p> <p><input type="checkbox"/> Appointment information</p> <p><input type="checkbox"/> Other: _____</p>

Rights of the Patient

I understand that 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 as described in this document by sending a written notification to Pinner Clinic, PA. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective moving forward from the date listed on the form. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Signature of Patient or Personal Representative

Date

Description of Personal Representative (Attach additional information as necessary)

This form will expire 1 year from the date listed on the form unless noted otherwise by patient. Form expiration date: _____

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Financial Policy

We are honored to be your Primary Healthcare Provider and appreciate you putting your trust in Pinner Clinic. We are committed to the success of your medical care. Prompt payment of your charges help us keep our fees down, so please take a moment to familiarize yourself with our financial policies.

Insurance:

We participate with many insurance plans and will bill participating insurance companies as a courtesy to you. You are expected to pay your deductible or copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance company. **If you need assistance or have questions about insurance, please contact a member of our Financial Services Team between 9:00 AM and 5:00 PM, Monday through Friday:**

- If you are a patient of **Carroll Pinner, MD**: Call 803-945-7475 **ext. 120**.
- If you are a patient of **Benjamin Pinner, MD**: Call 803-945-7475 **ext. 103**.
- If you are a patient of **Edwina Hallman, NP or Catie Thomas, NP**: Call 803-945-7475 **ext. 118**.

Co-Pays, Deductibles, Co-Insurances, and Payments:

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. *Please remember patient responsibility amounts are determined by your individual insurance plans, not Pinner Clinic. If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service.*

For your convenience we accept **cash, checks, MasterCard, Visa, American Express, and Discover**. There is a \$35.00 service charge for returned checks and your account will be put on a cash-only basis. Outstanding or overdue balances are due within 30 days unless prior arrangements have been made with Financial Services. If your balance is more than 90 days old, your account may be put in a hold status until further arrangements are made. **If you need assistance or have questions about payment, please contact a member of our Financial Services Team between 9:00 AM and 5:00 PM, Monday through Friday:**

- If you are a patient of **Carroll Pinner, MD**: Call 803-945-7475 **ext. 120**.
- If you are a patient of **Benjamin Pinner, MD**: Call 803-945-7475 **ext. 103**.
- If you are a patient of **Edwina Hallman, NP or Catie Thomas, NP**: Call 803-945-7475 **ext. 118**.

Non-Emergency Appointments:

We reserve the right to reschedule non-emergency appointments if there is an overdue balance on your account or if a co-payment is not made at the time of service.

Financial Policy, Continued

Family Medical Leave Forms/Short and Long Term Disability Forms:

We understand that at times, various forms or letters may be required to assist you with your health care needs. Because these forms can be time consuming, each provider reserves the right to charge a fee for affidavits, letters, or forms that we prepare for legal or employment matters. Those fees are not billable to your insurance company or employer and are due at the time of service. An office visit/appointment may also be required depending on the nature of the form and information request. Please allow 5-7 business days for completions of requested forms/letters.

Refunds:

If you have a credit on your account, we will gladly refund the amount within thirty days of your request (and if confirmed by Financial Services), or we can apply the credit to your account. You must provide a correct mailing address where your refund is to be sent.

Dismissal Process:

There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Abuse of prescription drugs and/or failure to adhere to Pinner Clinic's narcotic policy
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty days of the date of the letter, one of our providers will be available for advice. After thirty days, you will no longer be seen at our practice by any provider. A copy of your medical records may be forwarded to your new doctor after a formal request is made.

Financial Policy Acknowledgement

Please do not sign below unless you have read the Financial Policy.

Patient Acknowledgement: I, _____, have read, understand, and agree to Pinner Clinic, PA's Financial Policy. I agree to pay for services rendered at the time of service. I also understand that Pinner Clinic, PA reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I also understand the terms of this Financial Policy may be amended by the practice without prior notification to the patient or guarantor due to changes in regulations or practice operations.

Patient/Guardian Signature

Date

You may also review this Financial Policy at www.pinnerclinic.com

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Appointment No-Show Policy

It is the policy of Pinner Clinic to monitor and manage appointment no-shows. This is necessary to ensure that we are able to provide timely access to our providers for all patients. Unutilized appointments due to no-shows delays necessary medical care for other patients.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "No-Show."

After an established patient has three (3) no-show appointments, that patient and any person who is either a guarantor for, or guarantee of, the account in question may be discharged from our practice and asked to seek health care with another provider.

Patients seeking to establish care with Pinner Clinic ("new patients") who fail to cancel or reschedule their initial appointment at least 24 hours prior to the scheduled appointment are considered to be a "No Show" and will be denied entry to the practice.

A certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within thirty days of the dates of the letter, one of our providers will be available for advice. After thirty days, you will no longer be seen at our practice by any provider. A copy of your medical records may be forwarded to your new doctor after a formal request is made.

Appointment No-Show Acknowledgement

Please do not sign this form unless you have read the Appointment No-Show Policy.

Patient Acknowledgement: I, _____, have read, understand, and agree to Pinner Clinic, PA's Appointment No-Show Policy. I understand that Pinner Clinic, PA reserves the right to dismiss patients that fail to show to their appointments as listed above.

Patient/Guardian Signature

Date

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Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been given a copy of Pinner Clinic's Notice of Privacy Practices, and further understand that any questions may be directed to the Privacy Officer/Practice Administer at Pinner Clinic.

Patient Printed Name

Patient Signature

Date

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Patient Health Assessment

Patient Name (PLEASE PRINT): _____

Today's Date: _____ **DOB:** _____ **SS#:** _____

DRUG ALLERGIES: Please list ALL medications you are allergic to.

- | | | |
|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

- | | | |
|--|---|--|
| <input type="checkbox"/> Anemia / Low Blood
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding from Bowels
<input type="checkbox"/> Bleeding Problems, Type: _____
<input type="checkbox"/> Blood Clot in Leg
<input type="checkbox"/> Blood Clot in Lung
<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Cancer, Type: _____
<input type="checkbox"/> Communicable Disease, Type: _____
<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes / High Blood Sugar
<input type="checkbox"/> Emphysema / Chronic Bronchitis | <input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Gallstones
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hepatitis/Liver Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV
<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Kidney Disease, Type: _____
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Skin Disease, Type: _____
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Ulcers in Bowels / Stomach
<input type="checkbox"/> Varicose Veins or Spider Veins
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____ |
|--|---|--|

SURGICAL HISTORY: Please provide dates for any surgeries you have had.

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery <input type="checkbox"/> R <input type="checkbox"/> L	
Gallbladder	
Broken Bone Repair	
Joint Replacement	

SURGERY	DATE
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Tubal Ligation	
Hysterectomy (Complete? <input type="checkbox"/> Y <input type="checkbox"/> N)	
Mastectomy <input type="checkbox"/> R <input type="checkbox"/> L	
Other: _____	

CONTINUE →

Patient Health Assessment, continued

CURRENT MEDICATIONS: Please list ALL medications you are currently taking. Include dosage and how often you take each medication.

MEDICATION (including over-the-counter)	DOSAGE	HOW OFTEN DO YOU TAKE?

IMMEDIATE FAMILY HISTORY: Check beside any disease that has affected your mom, dad, brothers, and/or sisters.

<input type="checkbox"/> Heart Attack
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Asthma
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Kidney Disease

<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Diabetes / High Blood Sugar
<input type="checkbox"/> Thyroid Problems

<input type="checkbox"/> Cancer, Type:
<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Anxiety or Depression
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Other:
<input type="checkbox"/> Other:
<input type="checkbox"/> Other:

SPECIALISTS YOU ARE CURRENTLY SEEING:

Specialty	Specialist's Name	Location/Address	Phone Number

CURRENT HEALTH HABITS:

How often do you exercise? Never Occasionally Several Times Per Week Every Day

Have you ever smoked? Yes No

Number of Years: _____

How much do you/did you smoke every day? _____ # Cigarettes _____ # Packs

Do you use any of the following tobacco (other than cigarettes)?

Pipe Snuff Cigars Chewing Tobacco Dip Electronic Cigarettes Vapor

Patient Health Assessment, continued

Patient Name : _____ DOB: _____

Females ONLY:

Are you pregnant or planning to be pregnant soon? Yes No

Currently breast feeding? Yes No

Number of: Pregnancies? _____ Miscarriages? _____ Deliveries? _____

Have you ever had postpartum depression? Yes No Not Sure

Current form of birth control: _____

Date of most recent: Pap smear? _____ Mammogram? _____

Any abnormal results? _____

Date of most recent menstrual period: _____

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Pinner Clinic Patient Centered Medical Home (PCMH) Questionnaire

Please answer as many questions as you can. Circle your answers and add comments if desired.

Your care team will be able to help answer any questions you may have.

DATE: _____ PATIENT NAME: _____ DOB: _____

1. Tobacco Smoking Status:	Never / Former / Some Days / Everyday
2. If you smoke, describe how much you smoke:	_____
3. Smokeless tobacco status:	Pipe / Snuff / Cigars / Chewing Tobacco, Dip / Electronic Cigarettes, Vapor
4. Tobacco-years of use:	_____
5. E-cigarette/vape status:	Never/Former/Current
6. Most recent tobacco use screening:	_____
7. Do you have Advanced Directives in place?	Yes / No
8. Do you have a Medical Power of Attorney?	Yes / No
9. What is your current alcohol intake?	None / Occasional / Moderate / Heavy
10. Describe your current caffeine intake:	None / Occasional / Moderate / Heavy
11. Have you had any recent changes in family or social situations?	Yes / No
12. Describe your general stress level:	Low / Medium / High
13. Do you live alone or with others?	Alone / With Others
14. Are you exposed to passive (secondhand) smoke?	Yes / No
15. How would you describe the condition of your mouth and teeth, including false teeth or dentures?	Excellent / Good / Fair / Poor
16. How often do you see or talk to people that you care about and feel close to?	_____ days a week
17. In the past year, have been unable to get medicine or medical care when it was really needed?	Yes / No
18. Do you have any family members with known mental health conditions?	Yes / No
19. Do you have any family members with known alcohol abuse?	Yes / No
20. Do you have any family members with known drug abuse? (Prescription/Non-Prescription)	Yes / No
21. Do you have any known mental health conditions?	Yes / No
22. Support systems or programs currently being used?	Yes / No
23. Are you legally blind in one or both eyes?	Yes / No
24. Are you hard of hearing or deaf in one or both ears?	Yes / No
25. Are able to care for yourself?	Yes / No
26. Do you have difficulty concentrating, remembering, or making decisions?	Yes / No
27. Do you have a caregiver?	Yes / No
28. Describe your activity level:	None / Occasional / Moderate / Heavy

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name(s): _____ Social Security Number: _____

I Authorize: Name of Designated individual, Organization, or Provider:

Address: _____

Phone Number: _____ Fax Number: _____

TO: Release my health care information to

Pinner Clinic, PA

32 River Street

PO Box 99

Peak, SC 29122

P: (803) 945-7475 F: (803) 345-2832

for the purpose of Medical Care or Other: _____

Information to be Released:

Dates of Treatment:

All Medical Records

All Dates

All Medical Billing Records

Specific Dates: _____ to _____

X-Ray and Imaging Reports

Other: _____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization, I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).
7. This authorization will expire 90 days from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

Signature of Patient or Legal Representative

Date

Legal Representative Printed Name

Relationship to Patient