Frederick Health
Medical Group

1 Frederick Health Way
Frederick, MD 21701

FrederickHealth.org

Hello, and welcome to Frederick Health Medical Group!

We appreciate the value of your time. Here are some tips to help us provide comprehensive care in an efficient manner:

- Please bring your insurance card and photo ID with you.
- Payment is expected at time of service. We accept cash, checks, and all major credit cards.
- For patients visiting one of our specialists: if you are a member of an HMO, please contact your primary care physician to obtain a referral. Most offices require 48 hours' notice to issue a referral.
- For all new patients to our practices, please have appropriate records forwarded to us before your appointment. Your Doctor's office will either mail or fax them to our office, but you must request them. This includes any recent office notes, labs, or imaging.
- **Please arrive 30 minutes early to check in** and complete any paper work that may not be done. **You may be asked to reschedule if you arrive after your Check in time.**

We are working hard to ensure your time with us is as pleasant as possible. We are committed to your care and value any feedback you may have for us. Thank you and we look forward to seeing you!

Respectfully,

Your providers and staff at Frederick Health Medical Group

Patient Compact

Principles of Partnership

Frederick Health Medical Group

As your healthcare partner, we pledge to:

- Respect you as leader of the team.
- Allow you to select a personal provider and care team who will know you.
- Treat you with respect, honesty and compassion.
- Include your family, other partners or an advocate in your care when you request.
- Hold ourselves to the highest quality and safety standards.
- Be responsive and timely with our care and information to you.
- Listen to you and answer your questions.
- Provide information to you in a way you can understand.
- Help you to set goals for your healthcare and treatment plans.
- Provide you with information to help you make informed decisions about your care and treatment options.
- Communicate openly about benefits and risks associated with any treatments.
- Respect your right to your own medical information.
- Respect your privacy and the privacy of your medical information.
- Work with you, and other partners who treat you, in the coordination of your care.
- Provide educational resources, information about classes, support groups, or other services that can help you learn more about your condition.

As a patient, I pledge to:

- *Be a responsible and active member of my healthcare team, and participate in decisions about my care.*
- *Treat the whole team with respect, consideration and always tell the truth.*
- *Give you the information that you need to treat me.*
- *Tell you what medications/supplements I am taking.*
- *Inform you of all other provider visits, tests ordered, and medications prescribed by them and have them send us reports of your visit.*
- *Tell you if something about my health changes and any changes in my family, medical and social history.*
- *Learn about my health condition and let you know if there is something I do not understand.*
- *Understand my care plan to the best of my ability and follow my care plan that I have agreed upon or let you know if there are issues so the plan can be changed.*
- *Take all medications as prescribed and communicate to my team if there are issues such as cost or side effects.*
- *Communicate any questions using the patient portal or by phone.*
- *Tell you if I have trouble reading or hearing.*
- *Let you know if I have family, friends or an advocate to help me with my healthcare.*
- *Work with Frederick Health Medical Group and my insurance company to understand what my insurance plan covers. I will pay my share of any fees.*

A BETTER APPROACH TO YOUR HEALTHCARE

No matter your health needs, your primary care provider is here to help you maintain a healthy lifestyle. Evidence shows that access to primary care helps people live longer, healthier lives*—and patients with access to regular primary care providers have lower overall healthcare costs.**

What is a patient-centered medical home (PCMH)?

It's an innovative approach to primary care that meets patients where they are—in the right place, at the right time, and with the right care.

Accessible
Shorter wait times, "after-hours" care, 24/7 telehealth access, and stronger communication

Committed to quality and safety
Evidence-based medicine and clinical support

Comprehensive
A team of care providers—from physicians to nurses to nutritionists to social workers—for prevention, wellness, acute care, and chronic care

Coordinated
Open communication across all parts of the broader healthcare system, especially during transitions between sites of care

Patient-centered
Provides the education and resources you need to make smart decisions and become an active participant in your own care

Personalized
Addresses your personal health concerns and needs

Supportive and encouraging
Advice via phone, email, text, etc. from your health team to help you meet your goals and support you with health issues and concerns

Efficient
Saves you time

* Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/#b62

** Source: https://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf

It's not a place—**it's a partnership with your primary care provider.**

WHEN YOU THINK PCMH, THINK FREDERICK HEALTH MEDICAL GROUP!

Why Frederick Health Medical Group?

Frederick Health Medical Group is recognized by the National Committee of Quality Assurance as a PCMH. We partner with you and your healthcare team to provide the highest level of primary care possible.

Frederick Health Medical Group

With Frederick Health Primary Care, your healthcare team...

- Is just a phone call or portal message away
- Is your access point to Frederick Health and its wide array of services and specialists
- Collaborates with specialists to address all aspects of your healthcare
- May include a number of specialists, like in-house care coordinators, patient navigators, lab assistants, licensed clinical social workers, and more
- Offers telehealth, including email messaging and nurse access via the phone
- Offers the same level of service and care, no matter your insurance provider or payer

- ✓ 8 locations in Frederick, Myersville, and Mt. Airy
- ✓ Lower hospital readmission rates after a health event
- ✓ National Committee for Quality Assurance certified
- ✓ Open 7 days a week
- ✓ Same-day appointments and walk-ins

Call **240-215-6310** to find a primary care provider today! **FrederickHealth.org/PrimaryCare**

Choosing the Right Level of Care in a Medical Emergency

Frederick Health

Everyone knows that a primary care doctor is the best place to go when you are sick or in pain. By seeing your primary care physician on a regular basis, they will have your complete health history and an understanding of any underlying conditions you may have.

Sometimes you become sick or injured when the doctor's office is closed, and sometimes you need more urgent medical attention than your doctor can provide. This handout helps to explain **where to seek the best care in your time of need.**

Primary Care Call to make an appointment with your primary care provider if you have symptoms of a regular illness or need a regular check-up.

- Treatment of illness, including:
  - *Colds and coughs*
  - *Sore throat*
  - *Flu and flu-like symptoms*
  - *Ear infections*
  - *Urinary tract infections*
  - *Minor aches and pains*
  - *Allergies*
- Management of chronic conditions, such as:
  - *Diabetes*
  - *Heart Disease*
  - *COPD*
- General medical advice
- Annual Well Exams
- Immunizations
- Respiratory problems

If you believe a life is in jeopardy, always call 911!

Urgent Care is an option if you have a minor illness or injury, your primary care provider is not available, and your problem cannot wait.

- Treatment of illness, including:
  - *Colds, coughs, and upper respiratory infections;*
  - *Sore throat;*
  - *Flu and flu-like symptoms;*
  - *Ear infections/Earache;*
  - *Suspected urinary tract infection;*
  - *Sexually Transmitted Illness;*
  - *Fever* **If having seizures, go to the Emergency Department**
- Upset stomach
- Nausea or vomiting
- Adult IV hydration
- Skin rashes and infections
- Abscesses
- Sprains or suspected minor broken bones
- Musculoskeletal injuries
- Back pain or joint pain
- Toothache (if dentist is not available)
- Allergies
- Animal or insect bite
- Eye irritation and redness
- Minor cut/abrasion and sutures/stitching
- Minor burn
- Frequent, bloody, or painful urination
- Motor Vehicle Collision exams
- Workman's Comp exams
- Sports/DOT physicals
- Travel vaccines
- Laboratory and blood work
- X-Rays

(over)

The Emergency Department (ED) is open 24 hours a day, 7 days a week.

You should seek care at the Emergency Department without delay if you have a serious or a life-threatening illness or injury.

- Chest pain or other heart attacks symptoms, such as:
  Pressure, fullness, squeezing/pain in the center of your chest
  Tightness/burning/aching under the breastbone
  Chest pain with lightheadedness
- Signs of a stroke, such as:
  Sudden weakness or numbness of the face/arm/leg on one side of the body
  Sudden dimness or loss of vision
  Loss of speech or trouble talking
  Sudden severe headaches with no cause
- Head injury or eye injury
- Sudden and severe headache or loss of vision
- Heavy bleeding that won't stop
- Dislocated joints
- Severe abdominal pain
- Deep cuts or severe burns
- High fever
- Severe asthma attack
- Loss of consciousness
- Severe or worsening reaction to an insect bite, sting, or medications
- Constant, severe/persistent vomiting
- Coughing up or vomiting blood
- Poisoning **Call Poison Control at 1-800-222-1222 and ask for immediate home treatment advice**
- Domestic violence or rape
- Feelings of suicide

If you believe a life is in jeopardy, always call 911!

Patient Registration

Frederick Health Medical Group

Patient Information

PATIENT NAME (First, MIddle, Last) **DATE OF BIRTH** **PRIMARY CARE PROVIDER**

STREET OR MAILING ADDRESS (P.O. Box) **CITY** **STATE** **ZIP CODE**

HOME PHONE **CELL PHONE** **WORK PHONE** **EMAIL ADDRESS** (Required for Patient Portal)

PREFERRED CONTACT METHOD (Check all that apply): ☐ Home Address (Letter) ☐ Home Phone ☐ Cell Phone

PRIMARY LANGUAGE

EMPLOYMENT STATUS: ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Active Duty

EMPLOYER

STUDENT STATUS: ☐ Full Time ☐ Part Time ☐ Not a Student

EMERGENCY CONTACT NAME **RELATIONSHIP TO PATIENT** **PHONE** DAYTIME EVENING

BIRTH SEX
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

CURRENT GENDER
- ☐ Male
- ☐ Female
- ☐ Undifferentiated

SEXUAL ORIENTATION
- ☐ Choose not to disclose
- ☐ Straight or Heterosexual
- ☐ Bisexual
- ☐ Lesbian, gay, or homosexual
- ☐ Something else (please describe): _____

MARITAL STATUS
- ☐ Choose not to disclose
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Annulled
- ☐ Widowed
- ☐ Divorced
- ☐ Domestic Partner
- ☐ Life Partner

PREFERRED PRONOUN
- ☐ Choose not to disclose
- ☐ She, Her, Hers
- ☐ He, Him, His
- ☐ Ze, Hir
- ☐ They, Them, Theirs
- ☐ Other: _____

GENDER IDENTITY
- ☐ Choose not to disclose
- ☐ Female
- ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
- ☐ Male
- ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ☐ Genderqueer, neither exclusively Male nor Female
- ☐ Additional gender category or other (please specify): _____

RACE
- ☐ Choose not to disclose
- ☐ American Indian/Alaskan Native
- ☐ White/Caucasian
- ☐ Asian/Pacific Islander
- ☐ Black/African American
- ☐ Other: _____

ETHNICITY
- ☐ Choose not to disclose
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Other: _____

Responsible Party

RESPONSIBLE PARTY NAME (First, Middle, Last) **DATE OF BIRTH** **EMPLOYER**

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Guardian ☐ Self ☐ Spouse ☐ Other: _____

ADDRESS **HOME PHONE** **WORK PHONE**

SEX: ☐ Male ☐ Female ☐ Undifferentiated

Insurance Information

PRIMARY INSURANCE CARRIER

INSURANCE ID# **GROUP#**

SUBSCRIBER NAME (Policy Holder) **DATE OF BIRTH**

ADDRESS **PHONE**

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY INSURANCE CARRIER

INSURANCE ID# **GROUP#**

SUBSCRIBER NAME (Policy Holder) **DATE OF BIRTH**

ADDRESS **PHONE**

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

CONTINUED ON REVERSE

If you are here because of an injury, is it: ☐ **Work Related** ☐ **Auto Related** ☐ **Neither**

All Payment Is Due at Time of Service

I authorize payment of insurance benefits directly to Frederick Health Medical Group. Payment is due upon receipt of service. I will be responsible for fees and charges according to Frederick Health Medical Group and my health plan. If I do not provide a **valid** insurance card at each visit, I will be held responsible for services. I understand that I may be contacted by Frederick Health Medical Group and/or its affiliates on my cellular or home phone, which may include the use of Pre-recorded/artificial voice messages and/or an automatic dialing device ("auto dialer"), by text message, or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan.

PATIENT SIGNATURE OR PATIENT REPRESENTATIVE **DATE**

RELATIONSHIP TO PATIENT

Health Insurance Portability and Accountability Act (HIPAA)

Frederick Health
Medical Group

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of Frederick Health Medical Group, have been offered a copy of the Notice of Privacy Practice, which describes my privacy rights in accordance to federal and state requirements.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE   DATE

Communication Consent

I understand that I may be contacted by Frederick Health/Frederick Health Medical Group and or its affiliates on my cellular or home phone, which may include the use of pre-recorded/artificial voice messages, and /or an automated dialing device (auto dialer) or by text message or email in connection with any communication made to me or related to my accounts even if I am charged for the call under my phone plan. I understand that providing my phone number is not required to obtain services. You may also contact me by e-mail using any e-mail address I have provided to you.

☐ Yes, you may call or text my cell phone at: ____________________
This communication is to confirm office appointments or leave a message regarding my care.

☐ **No**, please **do not** contact me by the following means: ____________________

I authorize my provider and the appropriate staff to share medical/billing information about my care/account to the following individuals as indicated below.

NAME   RELATIONSHIP   PHONE   LANGUAGE
Allow disclosure of your healthcare information to this contact? ☐ YES ☐ NO
Authorize staff to speak with this contact regarding: ☐ Appointments ☐ Clinical ☐ Financial

NAME   RELATIONSHIP   PHONE   LANGUAGE
Allow disclosure of your healthcare information to this contact? ☐ YES ☐ NO
Authorize staff to speak with this contact regarding: ☐ Appointments ☐ Clinical ☐ Financial

NAME   RELATIONSHIP   PHONE   LANGUAGE
Allow disclosure of your healthcare information to this contact? ☐ YES ☐ NO
Authorize staff to speak with this contact regarding: ☐ Appointments ☐ Clinical ☐ Financial

It is the patient's responsibility to notify Frederick Health Medical Group of any changes to this form.

PRINT PATIENT'S NAME   PATIENT'S DATE OF BIRTH

HOME/CELL PHONE NUMBER (PLEASE CIRCLE ONE)

PATIENT OR LEGALLY RESPONSIBLE PERSON'S SIGNATURE   DATE

WITNESS   DATE

Patient Health History

Frederick Health Medical Group

PATIENT NAME (First, Middle, Last) **DATE OF BIRTH**

OCCUPATION

PRIMARY CARE PROVIDER (First and Last Name) **PHARMACY PREFERENCE** (Include location)

REASON FOR VISIT **DATE OF ONSET OF ILLNESS/INJURY**

Have you fallen in the past year? ☐ Yes ☐ No How many times? _____ Did the fall(s) result in an injury? ☐ Yes ☐ No

Do you use a walking aid or has one been recommended? ☐ Yes ☐ No ☐ N/A Details: _____

Past Medical History Check **all** conditions you have now or have had in the past.

CANCER
☐ TYPE: _____ YEAR: _____

CANCER
☐ TYPE: _____ YEAR: _____

CANCER
☐ TYPE: _____ YEAR: _____

CARDIOVASCULAR *(Heart & Blood Vessels)*
☐ Angina (chest pain)
☐ Arrhythmia/irregular heartbeat
☐ Blood clot/DVT (deep vein thrombosis) DATE: _____
☐ Heart attack/MI DATE: _____
☐ Heart disease/Coronary artery disease
☐ High cholesterol/Hyperlipidemia
☐ MVP (mitral valve prolapse)
☐ Varicose veins/Peripheral vascular disease
☐ Hypertension/High blood pressure
☐ Pacemaker YEAR: _____
☐ Stent DATE: _____
☐ AICD (Automatic Implantable Cardioverter Defibrillator)

BONES, JOINTS & MUSCLES
☐ Arthritis
☐ Fibromyalgia
☐ Gout
☐ Osteoporosis

MENTAL HEALTH
☐ Anxiety DATE: _____
☐ Bipolar Disorder DATE: _____
☐ Depression DATE: _____
☐ Drug/Alcohol abuse DATE: _____
☐ OTHER: _____ DATE: _____

HEENT *(Head, Eyes, Ears, Nose & Throat)*
☐ Blind DATE: _____
☐ Deaf DATE: _____
☐ Hearing loss DATE: _____
☐ Glaucoma DATE: _____

PULMONARY/RESPIRATORY
☐ Asthma
☐ Emphysema
☐ COPD (chronic obstructive pulmonary disease)
☐ PE (pulmonary embolism/blood clot in lung) DATE: _____
☐ Pneumonia
☐ Sleep Apnea
☐ Currently uses a C-PAP machine
☐ TB (tuberculosis) DATE: _____

GENITOURINARY *(Kidneys & Urinary Tract)*
☐ Renal failure
☐ Renal insufficiency
☐ UTI (urinary tract infection)

NEUROLOGIC DISORDER *(Brain & Nervous System)*
☐ Alzheimer's disease
☐ Dementia
☐ MS (Multiple Sclerosis)
☐ Parkinson's disease
☐ Seizure disorder
☐ Stroke/CVA/TIA DATE: _____
☐ Myasthenia gravis
☐ Muscular dystrophy
☐ Migraines
☐ Scoliosis
☐ Rheumatoid Arthritis

HEMATOLOGIC *(Blood & Lymph Node)*
☐ Anemia
☐ Hemophilia
☐ Sickle cell disease
☐ Clotting disorders
☐ Lupus

GASTROINTESTINAL *(Stomach & Digestive)*
☐ Colon polyps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ Hepatitis – Type unknown
☐ Hernia
☐ Irritable bowel
☐ Stomach ulcer
☐ Liver disease/Cirrhosis
☐ Acid Reflux
☐ Crohn's Disease
☐ Ulcerative Colitis

ENDOCRINE *(Hormones & Metabolic)*
☐ Diabetes – Type I
☐ Diabetes – Type II
☐ Diabetes – Type unknown
☐ Thyroid dysfunction
☐ Hypothyroidism (low)
☐ Hyperthyroidism (high)
☐ Hemoglobin A1C
☐ Thyroid Cancer

IMMUNE/AUTOIMMUNE & INFECTIOUS PROBLEMS
☐ AIDS DATE: _____
☐ HIV positive DATE: _____
☐ MRSA (Methicillin Resistant Staph Aureus) DATE: _____
☐ Lyme's Disease DATE: _____

Other medical conditions not listed above: _____

Past Surgical History Check **all** that apply and indicate which side R/L as appropriate.

- ☐ Joint surgery YEAR: _____ R/L
- ☐ Aneurysm YEAR: _____
- ☐ Angioplasty YEAR: _____
- ☐ Angio w/stent YEAR: _____
- ☐ Appendectomy YEAR: _____
- ☐ Arthroscopy YEAR: _____ LOCATION: _____ R/L
- ☐ Back surgery YEAR: _____
- ☐ Cardiac/Heart surgery YEAR: _____
- ☐ Cataract extraction YEAR: _____ R/L
- ☐ Colectomy YEAR: _____
- ☐ Colonoscopy YEAR: _____
- ☐ C- Section YEAR: _____
- ☐ Ear Tubes YEAR: _____
- ☐ Gallbladder YEAR: _____
- ☐ Gastric bypass YEAR: _____
- ☐ Hernia repair YEAR: _____
- ☐ Hip replacement YEAR: _____ R/L
- ☐ Hysterectomy YEAR: _____ Ovaries: R/L
- ☐ Knee replacement YEAR: _____ R/L
- ☐ Breast Surgery YEAR: _____ R/L
- ☐ Prostate YEAR: _____
- ☐ Thyroidectomy YEAR: _____
- ☐ Tonsillectomy YEAR: _____
- ☐ Tubal Ligation YEAR: _____
- ☐ Vasectomy YEAR: _____

OTHER SURGERIES NOT LISTED:

- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____
- ☐ OTHER _____ YEAR: _____

☐ Problems with Past Anesthesia (if yes, please list below):

_____

CURRENTLY BEING TREATED WITH:

- ☐ Dialysis
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Oxygen (Day/Night) _____ liters

Family History Has any member of your family (blood relatives) had one or more of the following diseases? If so, please mark the checkbox next to the condition and indicate which family member beside the condition name.

- ☐ Cancer/Type _____
- ☐ Cancer/Type _____
- ☐ Cancer/Type _____
- ☐ Cancer/Type _____
- ☐ Heart disease _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Alcoholism _____
- ☐ High blood pressure _____
- ☐ Depression _____
- ☐ Sickle Cell _____
- ☐ Tuberculosis _____
- ☐ Glaucoma _____
- ☐ Asthma _____
- ☐ High Cholesterol _____
- ☐ Kidney disorder _____
- ☐ Dementia _____
- ☐ Gout _____
- ☐ Suicide _____
- ☐ Epilepsy _____
- ☐ Thyroid disorder _____
- ☐ Bleeding disorder _____

Social History

ALCOHOL USE

Do you drink alcohol? ☐ None ☐ Rarely (social) ☐ Often # of Drinks per week: _____ ☐ Quit If so, when? _____

What type of alcohol do you drink? ☐ Beer ☐ Wine ☐ Hard liquor

CAFFEINE USE

☐ Daily AMOUNT & TYPE _____ ☐ Sometimes AMOUNT & TYPE _____ ☐ Never

TOBACCO USE: PRESENT

Do you currently smoke cigarettes regularly (at least one a day)? ☐ No ☐ Yes

Currently on average, how many cigarettes do you smoke per day? (one pack = 20) # OF CIGARETTES: _____

TOBACCO USE: PAST

In the past, have you ever smoked cigarettes regularly (at least 100 cigarettes)? ☐ No ☐ Yes

How many years have you smoked cigarettes regularly (at least once a day)? _____ YEARS

In the past on average, how many cigarettes did you smoke per day? (one pack = 20) # OF CIGARETTES: _____

If you have quit smoking, what year did you quit? _____

Do you currently smoke cigars/pipe/smokeless tobacco? ☐ No ☐ Yes

VAPING

Do you vape? ☐ Not currently ☐ Currently If you currently vape, how long have you been vaping? _____

What type of device(s) do you use? _____ Current Strength: Previous Strength:

How many times per day do you vape? _____

Do you vape for social reasons or in an effort to quit smoking? _____

Social History, continued

DRUG USE

Present ☐ No ☐ Yes If you answered "Yes," what type(s)? _____

Past ☐ No ☐ Yes If you answered "Yes," what type(s)? _____

Age quit: _____ Date quit: _____

Medications Please list any medication(s) you are currently taking, include prescribed medications, vitamins, supplements, and over-the-counter medications.

MEDICATION	DOSAGE/DIRECTIONS	PROBLEM BEING TREATED	PRESCRIBING DOCTOR

☐ **Medication List Copied**—see attached Medication List

Are you being treated by pain management? ☐ Yes ☐ No If so, where? _____

Allergies Please indicate your known allergies using the checkboxes below:

☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Latex
☐ Betadine
☐ Tape
☐ IVP dye
☐ Iodine/shellfish
☐ Eggs, birds/feathers
☐ Contact dermatitis
☐ Other: _____
☐ **I have no known allergies**

Please describe your reaction(s) to allergens, if any: _____

Current Treating Physicians

CARDIOLOGIST	PULMONOLOGIST	NEUROLOGIST
ENDOCRINOLOGIST	HEMATOLOGIST/ONCOLOGIST	OTHER

PATIENT/GUARDIAN SIGNATURE DATE OF BIRTH DATE

Authorization for Use and Disclosure of Health Information

Frederick Health Medical Group

All starred fields are required and must be completed.

PATIENT NAME* / / DATE OF BIRTH*

ADDRESS* CITY* STATE* ZIP*

EMAIL ADDRESS* PHONE*

I request that my Protected Health Information (PHI) from:

DR. (FIRST NAME)* LAST NAME*

ORGANIZATION NAME PHONE* FAX*

ADDRESS* CITY* STATE* ZIP*

Be disclosed to:

RECIPIENT NAME* PHONE* FAX*

ADDRESS* CITY STATE ZIP

I authorize the following PHI to be released from my medical records* (please select all applicable options)**:**

☐ Specific Dates: _____ to _____ or ☐ Full copy of record

☐ Office Visits from: _____ ☐ Immunizations ☐ Sleep Study Reports ☐ Preventative Exams

☐ Radiology Reports ☐ Surgery Consults ☐ Laboratory Reports ☐ Pathology Reports

☐ Other _____

Purpose for request: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care ☐ Other: _____

Disclosure Format: ☐ US Mail (paper) ☐ US Mail (Electronic) ☐ Fax (Healthcare provider only)

State and Federal Law protects the following. If this applies to you, please indicate if you would like this information released/obtained* (please select all applicable options):

Alcohol, Drug, or Substance Abuse Records	☐ Yes	☐ No	Dates: _____
HIV Testing and Results	☐ Yes	☐ No	Dates: _____
Mental Health Records	☐ Yes	☐ No	Dates: _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to fees in accordance with federal/state regulations.

** INDICATES REQUIRED FIELD*

CONTINUED ON REVERSE SIDE

- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented, mailed or faxed to the appropriate location listed above. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **expire** on the following date/event/condition*:

_____

- If I fail to specify an expiration date, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization, unless the treatment is part of a research project that requires this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand and agree to the Authorization terms.

_____ / _____ / _____

SIGNATURE OF PATIENT* DATE/TIME* SIGNATURE OF WITNESS DATE/TIME

If you are signing as a Representative for the above patient, you will be asked to provide ID.

_____ _____

YOUR NAME (PLEASE PRINT) RELATIONSHIP TO PATIENT

_____ / / _____

YOUR SIGNATURE DATE TIME

When this form is completed, please mail or fax to:

Frederick Health Medical Group
Attn: CBO – Medical Records – 3rd Floor
1 Frederick Health Way
Frederick, MD 21701
240-566-7751

To make sure that your request is processed efficiently and within a timely manner, please note the following:

- All starred fields are required and must be completed.
- If you are requesting medical records for someone other than yourself:

1. *Minors require a Parent/Legal Guardian*
2. *Adults require a copy of the POA (Power of Attorney), indicating that you have the right on the patient's behalf*
3. *Deceased patients require a copy of an updated POA (Power of Attorney) or court documentation establishing estate executorship*

Frederick Health Medical Group has contracted with CIOX; an outside vendor, to meet the needs of our patient's medical records copying requests. For any questions regarding a request, please contact us at 240-215-6310.

** INDICATES REQUIRED FIELD*