



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 complete the attached paperwork** and have it ready when you arrive for your visit.
- **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

Contact Us

Audiology

301-695-EARS (3277)

Brain & Spine

301-846-0100

Breast Surgery

301-418-6611

Chest Surgery

301-694-5861

Comprehensive Care Center

301-360-2574

Ear, Nose & Throat (Otolaryngology)

301-695-3100

Endocrine & Thyroid

240-215-1454

Gastroenterology

240-566-4820

Infectious Disease

240-566-3270

Medical Weight Loss

240-215-1474

Oncology & Hematology

301-662-8477

Orthopedics & Sports Medicine

301-663-9573

Precision Medicine & Genetics

301-663-9985

Primary Care

240-215-6310

Pulmonary Medicine

240-566-3201

Sleep Medicine

240-566-REST (7378)

Surgery

240-575-2526

Urology

301-663-4774

Wound & Hyperbaric Medicine

240-566-3840

Patient Compact

PRINCIPLES OF PARTNERSHIP

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.

Choosing the Right Level of Care

IN A MEDICAL EMERGENCY



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.**

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

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*
- Chronic conditions, including:
 - Diabetes*
 - Heart Disease*
 - COPD*
- General medical advice
- Annual Well Exams
- Immunizations
- Respiratory problems

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 seizing, go to Emergency Dept.*
- 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

Choosing the Right Level of Care

IN A MEDICAL EMERGENCY

Emergency Department (ED)

is open 24 hours a day, 7 days a week. 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 attack symptoms:
 - 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!**



A Better Approach to Your Healthcare

PATIENT-CENTERED MEDICAL HOME

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 lives¹—and patients with access to regular primary care providers have lower overall healthcare costs.²



Accessible

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



Committed to quality & 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 & 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

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.

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

¹ Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690145/#b62>

² Source: <https://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf>

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.

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

9 locations throughout
Frederick County

Lower hospital
readmission rates
after a health event

National Committee
for Quality Assurance
certified

Open 7 days a week

Same-day
appointments

Call 240-215-6310 to find a primary care provider today, or visit frederickhealth.org/PrimaryCare



Patient Registration

Patient Information

PATIENT NAME (First, Middle, Last, Suffix)	DATE OF BIRTH	PRIMARY CARE PROVIDER	
STREET OR MAILING ADDRESS (P.O. Box)	CITY	STATE	ZIP CODE
EMAIL ADDRESS (Required for Patient Portal)			
HOME PHONE	CELL PHONE	WORK PHONE	
PREFERRED CONTACT METHOD (Check all that apply): <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Home Address (Letter) <input type="checkbox"/> Portal			
EMPLOYER: _____	EMPLOYMENT STATUS:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Not Employed	
EMPLOYER PHONE: _____		<input type="checkbox"/> Retired <input type="checkbox"/> Homemaker <input type="checkbox"/> Active Military <input type="checkbox"/> Unknown	
EMPLOYER ADDRESS: _____			

EMERGENCY CONTACT NAME	RELATIONSHIP TO PATIENT	PHONE:	DAYTIME	EVENING
PRONOUN <input type="checkbox"/> Choose Not To Disclose <input type="checkbox"/> He, Him, His <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Ze, Hir	BIRTH SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated	LEGAL SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other <input type="checkbox"/> Unknown/Undifferentiated	GENDER IDENTITY <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male (FTM)/Transgender Male/Trans Man <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female (MTF)/Transgender Female/Trans Woman <input type="checkbox"/> Genderqueer, neither exclusively Male nor Female <input type="checkbox"/> Additional gender category or other (please specify): _____	
SEXUAL ORIENTATION <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Something else (please describe): _____				

PRIMARY LANGUAGE: _____ **INTERPRETER NEEDED?** Yes No

MARITAL STATUS

<input type="checkbox"/> Annulled	<input type="checkbox"/> Married
<input type="checkbox"/> Choose not to disclose	<input type="checkbox"/> Married, Common Law
<input type="checkbox"/> Divorced	<input type="checkbox"/> Single
<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Unknown
<input type="checkbox"/> Life Partner	<input type="checkbox"/> Widowed

RACE <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Unknown/Unable to Answer	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Other: _____	ETHNICITY <input type="checkbox"/> Cuban <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Decline to answer <input type="checkbox"/> Mexican or Chicano <input type="checkbox"/> Other Hispanic Origin <input type="checkbox"/> Unknown/Unable to answer
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ORGAN DONOR: Yes No

VETERAN STATUS: _____

Insurance Information

PRIMARY INSURANCE CARRIER

INSURANCE ID#**GROUP#**

SUBSCRIBER NAME (Policyholder)**DATE OF BIRTH**

ADDRESS**PHONE****RELATIONSHIP TO PATIENT:** Same as Patient Parent Spouse Other _____

SECONDARY INSURANCE CARRIER

INSURANCE ID#**GROUP#**

SUBSCRIBER NAME (Policyholder)**DATE OF BIRTH**

ADDRESS**PHONE****RELATIONSHIP TO PATIENT:** Same as Patient Parent Spouse Other _____

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

DATE OF INJURY

Responsible Party/Guarantor

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

ADDRESS**HOME PHONE****WORK PHONE****RELATIONSHIP** Parent Guardian Self**TO PATIENT:** Spouse Other _____**SEX:** Female Male Undifferentiated

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)

This form applies to all specialties within 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 clinical/medical/billing information about my care/account to the following individuals as indicated below as my Next of Kin and Person to Notify.

NAME of **Next of Kin** RELATIONSHIP PHONE LANGUAGE

NAME of **Person to Notify** RELATIONSHIP PHONE LANGUAGE

Same as Next of Kin

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

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: _____

Other medical conditions not listed above: _____

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: _____

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.

- | | | |
|--|--|--|
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Dementia _____ |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> Sickle Cell _____ | <input type="checkbox"/> Suicide _____ |
| <input type="checkbox"/> Cancer/Type _____ | <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Thyroid disorder _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Bleeding disorder _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Cholesterol _____ | |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Kidney 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:

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Betadine | <input type="checkbox"/> Contact dermatitis |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tape | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> IVP dye | <input type="checkbox"/> I have no known allergies |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Iodine/shellfish | |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Eggs, birds/feathers | |

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 _____

Frederick Health Hospital
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name _____

(Please print clearly & list any previous names)

Medical Record # _____

(office use only)

Patient Address _____

- Frederick Health Hospital
 Frederick Health Medical Group
 Both

Date of Birth ____/____/____

Phone (home) _____

For security, records may not be disclosed via email except by our copy service.

I authorize the use or disclosure of the above named individual's health information as described below:

Release Records FROM:	<input type="checkbox"/> _____ (facility name) Address _____ Phone _____ Fax _____														
Release Records TO:	<input type="checkbox"/> _____ (name of facility/organization/person) Address _____ Phone _____ Fax _____ <input type="checkbox"/> If records are being released to self, please check here if you want the envelope marked 'Personal and Confidential' <input type="checkbox"/> paper copies <input type="checkbox"/> electronic copy (CD) <input type="checkbox"/> electronic (fax) <input type="checkbox"/> electronic (email)														
Information To be Released or Reviewed	The following information is to be released (check appropriate boxes): <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> History & Physical Exam</td> <td><input type="checkbox"/> EKG/ECHO reports</td> </tr> <tr> <td><input type="checkbox"/> Consultations</td> <td><input type="checkbox"/> Radiology reports (films obtained from Radiology)</td> </tr> <tr> <td><input type="checkbox"/> Emergency Dept. Record</td> <td><input type="checkbox"/> Outpatient Rehab (PT/OT/ST) summary</td> </tr> <tr> <td><input type="checkbox"/> Operative report</td> <td><input type="checkbox"/> Drug, Alcohol, or HIV</td> </tr> <tr> <td><input type="checkbox"/> Discharge summary</td> <td><input type="checkbox"/> Psychiatric records</td> </tr> <tr> <td><input type="checkbox"/> Lab/Pathology reports</td> <td><input type="checkbox"/> Office Visits</td> </tr> <tr> <td><input type="checkbox"/> Other: please specify _____</td> <td><input type="checkbox"/> Full copy of record</td> </tr> </table> For the dates (s) of treatment _____	<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> EKG/ECHO reports	<input type="checkbox"/> Consultations	<input type="checkbox"/> Radiology reports (films obtained from Radiology)	<input type="checkbox"/> Emergency Dept. Record	<input type="checkbox"/> Outpatient Rehab (PT/OT/ST) summary	<input type="checkbox"/> Operative report	<input type="checkbox"/> Drug, Alcohol, or HIV	<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Psychiatric records	<input type="checkbox"/> Lab/Pathology reports	<input type="checkbox"/> Office Visits	<input type="checkbox"/> Other: please specify _____	<input type="checkbox"/> Full copy of record
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<input type="checkbox"/> Emergency Dept. Record	<input type="checkbox"/> Outpatient Rehab (PT/OT/ST) summary														
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<input type="checkbox"/> Discharge summary	<input type="checkbox"/> Psychiatric records														
<input type="checkbox"/> Lab/Pathology reports	<input type="checkbox"/> Office Visits														
<input type="checkbox"/> Other: please specify _____	<input type="checkbox"/> Full copy of record														
Purpose for Disclosure	I would like this information released for the following purpose: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Continued care by another</td> <td><input type="checkbox"/> Personal use</td> </tr> <tr> <td><input type="checkbox"/> Insurance</td> <td><input type="checkbox"/> Legal</td> </tr> <tr> <td><input type="checkbox"/> Social Security Disability</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Continued care by another	<input type="checkbox"/> Personal use	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Social Security Disability		<input type="checkbox"/> Other _____							
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<input type="checkbox"/> Social Security Disability															
<input type="checkbox"/> Other _____															

I have read and understood the following:

- Frederick Health Hospital will release all records of treatment for mental health, chemical dependence, sickle cell anemia, genetic conditions and AIDS/HIV. If I do not want these to be released, I indicate here that I do not want records released regarding the following: _____.
- If I change my mind, I may write to the facility that I have authorized to release my records. This will not apply to records that have already been released.
- This authorization expires one year after I sign it or sooner (specify here: _____) the time period noted here may exceed one year only in certain situations specified by law.
- There may be a fee for releasing these records which is in accordance with Maryland law.
- Once records are released, Frederick Health Hospital cannot prevent them from being released to a third party.
- To be valid, this form must be filled out completely and signed. A copy has not been altered.
- If I do not sign this form, I will still be treated, unless the treatment is part of a research project that requires this authorization.

Signature of patient _____ Date _____ Time _____

Authorized Representative _____ Date _____ Time _____

Print Name _____ Relationship to patient _____
 (Parent, guardian, power of attorney, etc.) (If authorized person is signing, please also print name)

ID checked/verified by HIM _____ Reason patient is unable to sign minor deceased other: _____

