Georgia Renal & Hypertension Care

Date:_____

Name:_____D.O.B_____

Address:_____

City:_____ State_____ Zip:_____

Gender: ❑Male ❑Female SSN:_____ E-mail_____

Telephone_____❑ Home ❑ Mobile Alternate number:_____

Marital Status:❑ Single ❑ Married ❑ Divorced ❑ Widowed

Are you currently working? ❑Yes ❑No If yes, current occupation:_____

Primary Insurance:_____ ID#_____Group#:_____

Secondary insurance:_____ID#_____Group#:_____

Tertiary Insurance:_____ID#_____Group#:_____

PolicyHolder ❑ Self ❑ Spouse ❑ Parent

Policy Holders Name:_____ D.O.B_____

Primary Care Physician:_____ City,& Phone #_____

Referring Physician:_____ City, Phone #_____

Emergency Contact Info

Name:_____Telephone:_____Relation:_____

Who do we have permission to release your information to ?

Name:_____Telephone:_____Relation:_____

Name:_____Telephone:_____Relation:_____

Georgia Renal & Hypertension Care

Please list all current medications:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Preferred Pharmacy:_____Telephone:_____

If mail order Pharmacy:_____

Do you have any drug allergies? ❑ No ❑ Yes Please list:_____

Past Surgeries:

❑ Bypass ❑ Hysterectomy ❑ Colon Surgery ❑ Tonsillectomy

❑ C-Section ❑ Pacemaker ❑ Heart Defibrillator ❑ Gallbladder

Other:_____

Do you have a history of any of the following?

❑High Blood Pressure	❑Sleep Apnea	❑Multiple Sclerosis	❑Neuropathy
❑Seizures	❑Stroke	❑High Cholesterol	❑Heart Disease
❑Parkinson's disease	❑Diabetes	❑Headaches	❑Dementia

❑Other:_____

Family Medical History:

❑ Aneurysm	❑Brain Tumor	❑Seizures	❑Stroke	❑Cancer
❑ Dementia	❑Diabetes	❑Headaches	❑Heart Disease	❑Depression

❑ Other:_____

Do you use Tobacco? ❑ Yes ❑ No Former Smoker: ❑ Yes ❑ No

Do you consume Alcohol? ❑Yes ❑ No How often:_____

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice

_____ _____

Patient Name(Please print) Date

_____

Parent or authorized Representative(If applicable)

_____

Signature

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and disclosures Not Requiring You Authorization.
In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purpose of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law

Patient Rights
As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please inform your Doctor

Georgia Renal & Hypertension Care

2326 Hwy 34 East, Suite 201
Newnan, Ga 30265
678-664-1545

Patient's Name Printed _____

Medical Records Release

Patient Name:_____ **Date of Birth:**_____

For the purpose of continuation of medical care, I hereby request to have my medical information described below, including but not limited to office progress notes, and reports from labs and other studies, summaries of treatment, consultation reports, and verbal/telephone/e-mail/contact, released to Georgia Renal & Hypertension Care.

The type and amount of information to be used or disclosed is as follows :

- **Most recent history and physical**
- **Most recent discharge and summary**
- **Laboratory results**
- **X-ray and imaging reports**
- **Consultation report**
- **Entire record**
- **Other:**

From _____ **To** _____

Georgia Renal & Hypertension Care

I understand that the information in my health record may include information relating to sexually transmitted disease, aquired immunodeficiency syndrome(AIDS), or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Record Services Department. I understand that the revocation will not apply to the information that has already been released in response to this authorization. This release will continue until termination of treatment unless otherwise specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the director of Medical Record Services.

Signature of Patient/Authorization Person Date