Chelmsford Family Practice

Primary Care for All Ages

Authorization to Use or Disclose Protected Health Information

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

Patient's Name: _____ Date of Birth _____ Social Security no. _____

Address (Street, City, State, Zip) _____ Phone: _____

I hereby authorize to release a copy of medical records obtained in the course of my treatment at

Name: _____

Address: _____

RELEASE TO:

Name: **CHELMSFORD FAMILY PRACTICE**
10 ADAMS STREET
P.O. BOX 248

Address: **NORTH CHELMSFORD, MA 01863**

Treatment dates:_____ **Purpose of request:** _____

ARE YOU LEAVING CHELMSFORD FAMILY PRACTICE _____YES _____NO

The following information is to be disclosed: (please check all that apply)

_____ Physician notes
_____ Lab results
_____ X-ray, Ct Scans, MRI, and other diagnostic imaging results
_____ Complete record
_____ Other: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV).
INITIAL HERE IF YOU DO NOT WISH TO HAVE THIS INFORMATION DISCLOSED _____,
It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
INITIAL HERE IF YOU DO NOT WISH TO HAVE THIS INFORMATION DISCLOSED _____.
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentially rules.
Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.
Other rights:

1. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in research study, my enrollment in the research study may be denied.
2. I understand that I may inspect or obtain a copy of the information to be used or disclosed.
3. Expiration: Unless otherwise revoked this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)

Signature of Patient: _____ **Date:** _____

If signed by legal representative, relationship to patient: _____

Cost of Records: You will receive a bill for copying your records. This must be paid before the records will be copied or released. Please allow two weeks for processing. Any questions please speak to Medical Records or Practice Administrator & Privacy Officer for Chelmsford Family Practice : 978 251-3159.

Your feedback is important to us. In order that we can better serve our patients please let us know the reason you are leaving this practice. I am leaving Chelmsford Family Practice, PC because

_____

REGISTRATION and HISTORY RECORD

milcom® A Division of Bilgo Corporation

The Society of Teachers of Family Medicine

YOUR FAMILY'S HEALTH

	First Name	Year of birth	Health is: Good	Poor	Died at	Age	Cause of death
Father			☐	☐	☐		
Mother			☐	☐	☐		
Brothers and Sisters			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
Spouse			☐	☐	☐		
Children			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
			☐	☐	☐		
Others Living in Household			☐	☐			
			☐	☐			
			☐	☐			

YOUR WORK/EXPOSURE HISTORY

Are you working now? ☐ Yes ☐ No. I'm out of work.

☐ No. I'm retired. ☐ I've never been employed.

Starting with your most recent job, what type of work have you done?

	Type of work	Years From	To
1.			
2.			
3.			

Check ☑ the items below that you have been exposed to in your work.

☐ Fumes and dust ☐ Coal, asbestos ☐ Extreme heat or cold

☐ Lead, mercury, metal salts ☐ Pesticides ☐ Heavy lifting, physical strain

☐ Solvents, degreasers ☐ Radiation ☐ Undue stress, pressure

☐ Salicylates, halothanes ☐ Loud noises ☐ Other _____

HEALTH CARE PROVIDERS

Who else have you seen for your health care in the past five years?

Year	Name of doctor or other provider	Location City, State	Primary Problems Cared For

ILLNESSES

Check ☑ where you or members of your family have had the following illnesses or problems:

You	Your family	
☐	☐	Alcoholism
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Cancer, tumor
☐	☐	Diabetes
☐	☐	Drug abuse
☐	☐	Depression
☐	☐	Eczema, hives, rashes
☐	☐	Epilepsy
☐		Eye problems
☐	☐	Glaucoma
☐	☐	Heart disease
☐	☐	High blood pressure
☐	☐	HIV
☐	☐	Kidney/bladder problems
☐	☐	Liver disease, hepatitis, yellow jaundice
☐	☐	Lung disease, tuberculosis
☐		Mumps, measles chicken pox
☐	☐	Nervous breakdown/ mental illness
☐	☐	Phlebitis
☐	☐	Rheumatic fever
☐		Rubella, German measles
☐	☐	Sexually transmitted disease
☐	☐	Stroke
☐	☐	Suicide attempt
☐	☐	Thyroid disease
☐	☐	Ulcer in stomach/ duodenum
☐	☐	Uncontrolled bleeding
		Other illnesses:
☐	☐	_____
☐	☐	_____

PREGNANCY HISTORY

Enter the number of:

Times pregnant ..... ____

Premature births ..... ____

Miscarriages ..... ____

Abortions ..... ____

Live births ..... ____

Living children ..... ____

Updated on	/	/	/
by			

PATIENT NAME_____

DATE OF BIRTH_____

MEDICINES YOU ARE TAKING (List medicines, birth control pills, or vitamins you take with or without a prescription):

_____
_____
_____
_____
_____
_____

DRUG and/or OTHER ALLERGIES (List those to which you are allergic):

_____
_____
_____

HOSPITALIZATIONS (List serious illnesses and injuries or operations and approximate year):

Year	Serious illness, injury or operation	Hospital	City/State

NAME AND ADDRESS OF GYNECOLOGIST

_____

IMMUNIZATIONS (check those that you have had. Note most recent year received)

Pneumonia _____
Polio _____
Flu _____
Tetanus _____
Rubella _____
Others _____ _____ _____

OVER →