PORTLAND
FAMILY WELLNESS

HIGHPOINT HEALTH PARTNERS

Patient Health Information Form

Date:_______________________________
Patient Name: _______________________________ **DOB:**_______________________
Pharmacy (***name and number***)_______________________________________
(All new prescriptions and refills will be submitted electronically to your designated pharmacy)

What is the reason for your visit today? ______________________________________
Were you born between 1946 and 1964?________ **Have you been tested for Hepatitis C?**______

Medical History: (Please circle all that apply)

Heart Disease	Stroke	High blood pressure	Diabetes
High Cholesterol	Asthma	COPD	Seizure
Thyroid problems	Liver disease	Hepatitis C	Hepatitis B
Acid Reflux	Irritable Bowel	Back pain	Fibromyalgia
Migraines	Anxiety	Depression	Crohn's
Ulcerative Colitis	Kidney disease	Cancer (list type)______________________	

In general do you have any of the following symptoms? **(Circle all that apply)**

Trouble swallowing	Hoarseness	Constipation
Always Tired	Rectal Bleeding	Rectal Pain
Loss of appetite	Sore throat	Diarrhea
Weight loss/gain	Cough	Black/tarry stools
Shortness of breath	Hemorrhoids	Heartburn/acid reflux
Hepatitis	Loose stools	Abdominal pain
Nausea	Colon cancer	Abdominal bloating
Ulcers	Chest pain	Pelvic pain
Falls/stumbling	Vomiting/dry heaves	Recent imaging/labwork

Past Surgical History:

Surgery_______________________________________ Date:____________________

Surgery_______________________________________ Date:____________________

Surgery_______________________________________ Date:____________________

Recent Hospitalizations/REASON:____

____

Family History: (Check all that apply) parents alive or deceased

	Alive or Cause of Death	Colon cancer	Other cancer	High blood pressure	Heart Disease	Liver Disease	Abnormal Cholesterol	Diabetes	Thyroid Problems
Mother									
Father									
Brother									
Sister									
Son									
Daughter									
Grandparents									

Medications: (List all prescription and over the counter medications that you are currently taking)

Medication	Reason for taking	Dosage	Directions
Do you take aspirin? Yes/NO			

Allergies: (circle all that apply)

Sulfa   Penicillin   Statins (cholesterol medication)   Codeine

Latex   Other allergies: ____

Social History: (Check all that apply)

Tobacco Use: None____ 1pk/day____ 1+pk/day____ former smoker (year stopped)________

Alcohol Use: None____ social_____ 1/day_____ 2-3/day____ 4+/day____ year stopped_____

Street Drugs: Never______ In the past_______ Occasionally ______ Frequently_______

Signature:____ **Date:**____________

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name:______________________________

Patient's Address:____________________________

City, State, Zip:______________________________

Date of Birth:____________ Telephone No:______________

Medical Record #:_____________________________

SS#______________________________

Portland Family Wellness
700 S. Broadway
Portland, TN 37148
P(615)325-3100 F(615)325-0076

Release Of Information From Portland Family Wellness

☐ I authorize Portland Family Wellness to release copies of my medical records as listed below. The information should be sent to:

____
Name of physician, Institution, Self, etc.

____
Address

____
City, State, Zip

______________ ______________
Telephone Number Fax Number

Release Information To Portland Fam.Wellness

☐ I authorize the release of information from:

____
Name of Physician, Institution, Self, etc.

____
Address

____
City, State, Zip

______________ ______________
Telephone Number Fax Number

DATES OF TREATMENT (Which dates of treatment do you need records for?)

Dates:_**ALL unless specified ->**_______________________________

The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

***Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Highpoint Health Systems*.**

Information to be Released

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ X-ray
- ☐ Clinic Visits
- ☐ ER Records
- ☐ EKG
- ☐ Lab
- ☐ Physician Orders
- ☐ Continuity of Care Documents (CCD)
- ☐ Other

Purpose of Release

- ☐ Attorney
- ☐ Social Security
- ☐ Continuation of care
- ☐ Workmen's Compensation
- ☐ Disability
- ☐ Insurance
- ☐ Deposition
- ☐ Billing
- ☐ Other (Please Specify)

Expiration date for expressed authorization is **365 days from signature date.** If the patient does not express a desire for a specific date or condition to their authorization, this authorization will expire 90 days from the date signed by the patient or legal representative.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exists, as detailed by federal law, such as:

- PFW has taken action in reliance thereon or
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.

  In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the privacy officer or Fairview Family Wellness. This revocation document must contain signature of the patient or patient's legal representative. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

______________________________ ______________
Signature of Patient or Appropriate Legal Representative Date

____

In order to be valid, the signature on the authorization must be on/after the date of service that is being requested for release.

______________________________ ______________
Witness Date