Greenville Family Medicine, LLC

Community Partners for Healthcare Excellence

NEW PATIENT APPLICATION

NAME ______________________ DOB ______________________

ADDRESS ______________________ CITY ______________________

PHONE NUMBER (HOME) ______________________ (CELL) ______________________

INSURANCE ______________________

CURRENT FAMILY PHYSICIAN ______________________

OTHER SPECIALISTS YOU ARE CURRENTLY SEEING ______________________

HOW DID YOU HEAR ABOUT US? ______________________

FAMILY MEMBERS WHO ARE CURRENT PATIENTS OF GFM

NAME ____________ RELATIONSHIP ____________ DOCTOR ____________

NAME ____________ RELATIONSHIP ____________ DOCTOR ____________

CIRCLE PREFERRED PROVIDER:

ANY DR SIEFKEN DR HOPKINS HEATHER ANGELICA JENNIFER

MEDICATIONS (LIST ALL PRESCRIPTIONS) THIS OFFICE DOES NOT ENCOURAGE CHRONIC NARCOTIC USE IN MOST SITUATIONS.

____________________ ____________________

____________________ ____________________

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BRIEF MEDICAL/SURGICAL HISTORY * ***Please list all conditions in which you will be seeking treatment to ensure we provide you with comprehensive care. By filling out this application, you are agreeing to provide necessary medical information.***

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DATE RECEIVED: ______________________

APPROVED BY/DATE: ______________________

NEW PT APPT: ____________ TIME: __________ SCHEDULE BY: ____________

DATE PATIENT INFORMED: ____________

1000 RED BALL TRAIL, GREENVILLE, IL 62246 PHONE 618-664-1240 FAX 618-690-2189

Greenville Family Medicine, LLC

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Authorization for Release of Medical Information

Patient Name ______________________________ SSN ________________ Date of Birth ______________

Previous Doctor and phone number (where we need to send request) ____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure.

Please do not fax anything over 25 pages and please do not send double sided pages

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

   - Complete Medical Records including any mental health records
   - History and Physical
   - Discharge summary
   - Progress notes
   - Laboratory results
   - X-ray and imaging reports
   - Consultation reports

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

5. This information may be disclosed to and used by the following individual or organization:

   Greenville Family Medicine LLC Address 1000 Red Ball Trail, Greenville, IL 62246 Fax 618-690-2189
   Purpose: Continuing Care Restrictions, if any ______________________
   I understand that information used or disclosed is prohibited from re-disclosure by the recipient.

6. 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 Health Information Department. I understand that the revocation will not apply to information that has already been release in response to this authorization. I understand that the revocation will not apply to my insurance company where the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire on the following date, event or condition__________________________. If I fail to specify an expiration date, event or condition, this authorization will expire within 90 days of date of signature.

7. 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 CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure of my health information. I can contact the Health Information Department Manager at 618-664-1240 to discuss the release of health information.

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Signature of patient or legal representative Date

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If signed by legal representative, specify relationship Signature of Witness