Care Medical Center

Patient Questionnaire

Patient Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

Email: _____ Height: ____ Weight: _____ Referred By: _____

SSN#: ____-____-____ Date of Birth: ____/____/____ Sex: Male/Female

Chief Complaint: _____

Accident Information:

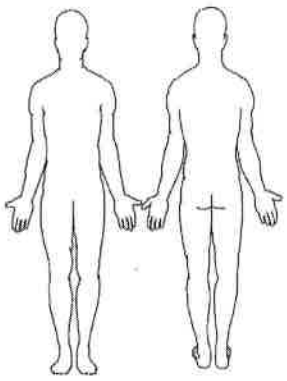
Is your condition due to an accident? □ Illness □ Other _____

Did your accident occur while at work? □ Yes □ No Were you involved in an automobile accident? □ Yes □ No

Date _____ Time _____ Injury reported to employer □ Yes □ No Name of Supervisor: _____

Location:

- □ Head
- □ Neck
- □ Shoulder
- □ Arm
- □ Back
- □ Thorax
- □ Elbow
- □ Wrist
- □ Hip
- □ Knee
- □ Ankle
- □ Foot



Quality:

- □ Achy
- □ Dull
- □ Sharp
- □ Stabbing
- □ Throbbing
- □ Radiating
- □ Burning
- □ Itching
- □ Numb
- □ Pins & Needles

Time of Day:

- □ Morning
- □ Afternoon
- □ Evening
- □ Bedtime
- □ All the time
- □ Varies

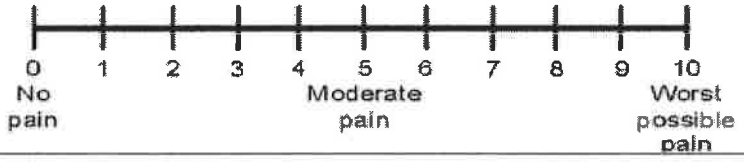
Modifying Factors:

	Increase	Decrease
Standing	□	□
Sitting	□	□
Walking	□	□
Climbing	□	□
Bending	□	□
Squatting	□	□
Sleeping	□	□
Up Stairs	□	□
Down Stairs	□	□
Driving	□	□
Coughing	□	□
Touch	□	□
Sneezing	□	□
Movement	□	□

Neurological Signs & Symptoms:

- □ Bowel Dysfunction
- □ Bladder Dysfunction
- □ Motor Loss
- □ Sensory Loss
- □ Radiation to Arm
- □ Radiation to Leg

Numerical Pain Scale:



Medications:	**Dosage:**	**Allergies:**	**Primary Care Physician:**
1.	1.	1.	Name:_____
2.	2.	2.	Address:_____
3.	3.	3.	Phone:_____
4.	4.	4.	**Imaging HX:**
5.	5.	5.	What?
6.	6.	6.	When?
7.	7.	7.	Where?
8.	8.	8.	Who ordered it?
9.	9.	9.	
10.	10.	10.	

Family Hx:	**Social Hx:**	**Medical Hx:**	**Surgical Hx:**
☐ Heart Disease	**Marital Status:**	☐ Diabetes	☐ Appendectomy
☐ High BP	☐ Single	☐ Hypertension	☐ Tonsillectomy
☐ Stroke	☐ Married	☐ Thyroid	☐ Inguinal Hernia
☐ Cancer	☐ Separated	☐ Heart Disease	☐ Ventral Hernia
Type:_____	☐ Divorced	☐ Stroke	☐ Umbilical Hernia
☐ Tuberculosis	☐ Widowed	☐ GI Disorder	☐ Cholecystectomy
☐ Bleeding Tendency	**Alcohol:**	☐ Hepatitis	☐ Hysterectomy
☐ Diabetes	☐ Never	☐ Kidney Disorder	☐ Cesarean Section
☐ Arthritis	☐ 0-1 / Week	☐ Cancer	☐ CABG
Type:_____	☐ 1-5 / Week	☐ Ulcer	☐ Coronary Stent
	☐ Other:_____	☐ Seizure	☐ Carotid
Other:	**Tobacco:**	☐ Asthma	☐ Endarterectomy
	☐ Never	☐ Mental Illness	☐ Angioplasty
	☐ Quit	☐ Infections	☐ Vascular Bypass
	☐ When? _____	☐ Anemia	☐ Craniotomy
	Packs per day ____	☐ Pregnancy	☐ Total Hip
	Years Smoked ____		☐ Total Knee
	Illegal Drugs?	Other:	☐ Rotator Cuff
	Y or N		☐ Carpal Tunnel
	Occupation:		☐ Release
	_____		☐ Adverse RXN
			☐ Anesthesia
			☐ Lumbar
			☐ Laminectomy
			☐ Cervical Fusion
			☐ Arthroscopy
			☐ Ganglion
			☐ Mastectomy
			☐ Prostatectomy

OTHER DOCTORS SEEN FOR THIS CONDITION: **MD ☐** **DC ☐** **DO ☐** **DDS ☐**

_____

_____

_____

_____

_____

_____

INFORMED CONSENT FOR TREATMENT

Thereby request and consent to the treatment of medical care, physical therapy and/or chiropractic adjustments. This includes various modes of physical therapy, chiropractic, diagnostic x-rays, and possible medication and/or injections prescribed to me (or to the other patient named below, for whom I am legally responsible). I request to be treated by the doctors named below and/or other licensed doctors who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctors named below, including those working at Care Medical Center.

I have had an opportunity to discuss with the doctors named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treating including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I also understand that there are risks to taking medication including, but not limited to, rash, diarrhea, nausea, low grade fever, dry mouth, restlessness, night sweats, increased heart rate, and depression as prescribed by the medical doctor. I do not expect the doctors to be able to anticipate and explain all risks and complications, and I wish to rely on the doctors to exercise judgement during the course of the procedure which the doctors feel at the time, based upon the facts then known, is in my best interests.

I have read or have had read to me, the above consent I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition(s) for which I seek treatment.

TO BE COMPLETED BY PATIENT

Patient Name _____ Signature of Patient _____

Date Signed _____ Witness of Patient's Signature _____

TO BE COMPLETED BY PATIENT'S REPRESENTATIVE IF PATIENT IS A MINOR OR PHYSICALLY OR LEGALLY INCAPACITATED

Patient Name _____ Signature of Patient _____

Date Signed _____ Signature of Representative _____

Relationship/Authority of Representative_____

Translated by_____

TO BE COMPLETED BY DOCTOR OR STAFF

Date_____

NAME OF CLINIC/OFFICE: CARE MEDICAL CENTER

ADDRESS: 2804-C N. OAK ST. VALDOSTA, GA 31602

NAME OF DOCTOR'S TREATING THIS PATIENT:

Medical: Kate Paylo, D.O., James Campagna, M.D., Wiley L. Drury (Don), M.D, A.J. Davis, F.N.P.-C, Nathan Roberson, N.P.-C

Chiropractic: J. Ryan Moorman, D.C., Daniel Day, D.C., Briggs Smotherman, D.C.

Physical Therapy: Joshua Rhue, DPT, Laura Gwillim, P.T., Jonathan Howell, P.T.A., Rebecca Adams, P.T.A., Zoe Chung, P.T.A

Care Medical Center

Office Financial Policy

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out of pocket expense and allows you to place your family under care.

1. If You Do Not Have Insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. If You Have Insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your complete insurance information, and we qualify and accept your insurance coverage.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

3. Payment Options: An affordable payment plan will be given at your report of findings. We offer payment by cash, check, post-dated check, credit card or by care credit.

If you are a Medicare patient and your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

Patient Name:_____ Date:_____

Signature:_____ Date:_____

Finance Counselor: _____ Date: _____

Front Desk:_____ Date:_____

For your convenience you may retain your credit card on file with us. (OPTIONAL)

Card # _____ Exp. Date: _____

Name as it appears on the card: _____ CVC on back of card: _____

Care Medical
Spine, Pain & Rehab

PRIVACY ACT OF 1974

The Privacy Act of 1974, 5 U.S.C. 552a, prohibits disclosures of records contained in a system of records maintained by a federal agency (or its contractors) without the written request or consent of the individual to whom the record pertains. This general rule is subject to various statutory exceptions. In addition to the disclosure information for other purposes compatible with the purpose for which the information was collected by identifying the disclosure as "routine use" and publishing notice of it in the Federal Register. The Act applies to all federal agencies and certain federal contractors who operate Privacy Act systems of records on behalf of federal agencies. Some federal agencies and contractors of federal statutes and regulations. For example, if the privacy regulation permits a disclosure, but the disclosure is not permitted under the Privacy Act, the federal agency may not make the disclosure. If, however, the Privacy Act allows a federal agency the discretion to make a routine use disclosure, but the privacy regulation prohibits the disclosure, the federal agency means not making the disclosure.

Signature: _____ Date: _____

HIPPA Notice of Privacy Practices

Care Medical Center

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out our treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and any information that relates to your past, present or future physical or mental health condition and related healthcare services.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT: We will use and disclosed your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose you protected health information in the following situations without your authorization. These situations included as Required by Law, Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; defense of professional liability claims asserted by patients, Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law we must make the disclosure to you, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT. UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time, in writing, except to the extent that this practice has taken an action in reliance on the use of disclosure indicated in the authorization.

2. YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request restriction of you protected health information. This means you may ask not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your doctor is not required to agree to a restriction that you may request. If your doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to have your doctor amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made of any of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You my make a complaint to our office or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer at (229) 241-8925 of your complaint. We will not retaliate against you for filing a complaint.

_____ _____

Signature Date

Care Medical Center
Narcotic Agreement

Patient Name: _____ DOB: _____

I agree to use opioids (morphine-like drugs) and/or scheduled drugs as part of my treatment for chronic pain. I understand that these drugs are very useful, but have a potential for misuse and therefore, are closely controlled by the local, state and federal government. Because my provider is providing such medication to help manage my pain, I agree to the following conditions:

1. I AM RESPONSIBLE FOR MY PAIN MEDICATION.
    a. I agree to take the medication only as prescribed. **Initial _____**
    b. I understand that increasing my dose without the close supervision of my provider could lead to drug overdose causing severe sedation, respiratory depression and death. **Initial _____**
    c. I understand that decreasing or stopping my medication without the close supervision of my provider can lead to withdrawal. Withdrawal symptoms may include yawning, sweating, watering eyes, runny nose, anxiety, tremors, aching muscles, hot or cold flashes, "goose flesh:, abdominal cramps and diarrhea. These symptoms can occur 24-48 hours after the last dose and last up to 3 weeks. **Initial _____**
2. I will not request of accept controlled substance medication from any other provider or individual without notifying our office first. Doing so may result in dismissal from the Opioid program or discharge from the practice. **Initial _____**
3. I understand the side effects that are related to opioid/scheduled drug medication. Common side effects are nausea and vomiting (similar to motion sickness), drowsiness and constipation. Lesser side effects are mental slowing, flushing, sweating, itching, urinary difficulties and jerkiness. These side effects would occur at the beginning of any treatment and often go away within a few days without any treatment. **Initial _____**
4. I understand that I must contact my pain provider before taking alcohol and other drugs such as sedatives, antihistamines and muscle relaxants. These include medication like **VALIUM, ATIVAN, SOMA, XANAX, FIORINAL and BENADRYL.** These may produce profound sedation, respiratory depression; drop in blood pressure and even death when taken with opioids. **Initial _____**
5. I understand that the opioid/scheduled drug medication prescribed is strictly for my own use and should never be given to others. **Initial _____**
6. During the time my opioid/scheduled drug dose is being adjusted, I will return to Care Medical Center at least one time per month or whenever instructed by my provider. **Initial _____**
7. In the event of medication changes (for any reason); ALL unused pills must be returned to Care Medical Center. No new medication prescription will be written until all unused medication is returned to the office to be counted and destroyed. Patients may not destroy and/or dispose of controlled/scheduled medications on their own. **Initial _____**
8. **I AM RESPONSIBLE FOR MY OPIOID/SCHEDULED DRUG PRESCRIPTIONS AND REFILLS.**
    a. Opioid/Scheduled drug prescriptions will not be called to my pharmacy. They must be picked up at Care Medical Center at my regularly scheduled appointment. **Initial _____**
    b. Prescriptions can only be written for a one-month supply and will be filled at the same pharmacy each time. **Initial _____**
    c. REFILL PRESCRIPTIONS WILL BE WRITTEN DURING REGULAR OFFICE HOURS ONLY. They will not be written and night, on weekends or holidays. **Initial _____**

Patient Name: _____ DOB: _____

d. Prescriptions will **not** be given if "I ran out early", "lost", "spilled", or "misplaced" my remaining medications. **Initial _____**

9. I am responsible for taking the medication the way it has been prescribed to me and for keeping track of the amount remaining. If my medication is stolen I will report it to my local police department and obtain a stolen item report**. A replacement prescription will be given at the discretion of the provider. Initial _____**
10. I will call Care Medical Center at least one month in advance to schedule an appointment to have my prescription refilled **if not already scheduled for a return appointment**. I am aware that if I give less than one-month notice, I may not be able to schedule an appointment in a timely manner. **Initial _____**
    a. "No-Showing" your appointment is considered a violation of this contract. **Initial _____**
11. I will bring unused pain medication to every office visit. **Initial _____**
12. A Monitoring Log will be kept with taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. A drug-dependence treatment program may also be recommended**. Initial _____**
13. In this case, my provider will taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. A drug-dependence treatment program may also be recommended. **Initial _____**
14. FORGING OR STEALING PRESCRIPTIONS, stealing or selling narcotics/scheduled drugs, use of illicit drugs or abuse of alcohol is subject to discharge from the program. **Initial _____**
15. I understand as part of my treatment plan there are risks for dependency and addiction with certain medications. But I also understand that *not* following the treatment plan (medications and/or procedures) as prescribed could pose a greater risk to my overall health and well-being. Patient verbalizes understanding of the potential dangers associated with taking prescription opioids including, but not limited to; side effects, possible addiction and/or potential interactions with other medications. Patient given options regarding opioid addiction and treatment for detoxification. All questions were answered. **Initial _____**
16. I understand that "overdose" is a risk of opioid therapy which can lead to death. I understand and can recognize the signs and symptoms of overdose including respiratory depression. **Initial _____**
17. I understand that I have been given the option and it is recommended naloxone be prescribed because overdose is a risk of opioid therapy. I understand that naloxone is a drug that can reverse opioid overdose. I understand when and how to use naloxone.
    a. I understand it is strongly encouraged to share information about naloxone with my family and friends.
    b. I understand it is strongly encouraged to teach family and friends how to respond to an overdose. **Initial _____**
18. While physical dependence is expected after long-term use of opioids, signs of addiction and/or psychological dependence shall be interpreted as a need for tapering and detoxification.
    a. **PHYSICAL DEPENDENCE** is common to many drugs. These include blood pressure medication, anti-seizure medication and opioids. An abrupt stopping of these drugs can result in biochemical changes that will cause a withdrawal response. **Initial _____**
    b. **ADDICTION** is a psychological and behavioral syndrome that is recognized when the patient abuses the drug to obtain mental numbness and euphoria, shows a craving behavior, or tends to "doctor shop". Also when the drug is quickly escalated without correlation to pain relief and/or when the patient shows manipulative attitude toward the provider and/or staff, in order to obtain the drug**. IF THE PATIENT EXHIBITS SUCH BEHAVIOR, THE DRUG WILL BE TAPERED AND THE PATIENT MAY BE DISCHARGED FROM THE CENTER. Initial _____**
    c. **TOLERANCE** to a pharmacological property of certain drugs is defined as a need for higher does to maintain the same drug related effect. **Initial _____**

Patient Name: _____ DOB: _____

19. If it appears to the provider that there is no improvement to my daily function or quality of life from the controlled substance, my opioid/scheduled drug treatment may be discontinued. I will gradually taper my medication as prescribed by my provider. **Initial _____**
20. I agree to submit to urine and blood screens at any time as determined by my provider to detect the use of both prescribed and non-prescribed medications.
    a. Urine screens must performed immediately upon the request of Care Medical Center**. LAW ENFORCEMENT AUTHORITIES MAY BE NOTIFIED REGARDING OUR FINDINGS IN URINE DRUG SCREENS.**
    b. A no show may be cause for immediate dismissal from the opioid/scheduled drug program. Initial _____
21. I agree to random pill counts. Presentation of medication must be within the designated time frame determined by Care Medical Center. You **must** provide a valid/working phone number/contact information so we will be able to contact you. Failure to comply may be cause for immediate dismissal from the opioid program. **Initial _____**
22. I hereby attest that I am not currently, and there does not exist the possibility of my becoming pregnant at this time. Should the risk of pregnancy occur, I will immediately inform the physician and/or staff of Care Medical Center and my treatment will immediately be transferred to my obstetrician. **Initial _____**
23. I hereby assume all responsibilities for any potential complications resulting the use of narcotics/scheduled drugs on the fetus if I do not inform the staff at Care Medical Center possibility of pregnancy. **Initial _____**
24. I authorize the provider and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including Georgia's Medical Board and Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. **Initial _____**

PATIENT:

I have read the above information and it has been reviewed with me. All of my questions regarding the treatment of pain with opioids/scheduled drugs have been answered to my satisfaction. I hereby give my consent to participate in opioid/scheduled drug medication therapy.

Patient's Signature _____ Date _____/_____/_____

Patient Name (Printed) _____

I have explained/reviewed the Opioid Agreement with the patient. I have answered the questions the patient's questions pertaining to the Opioid Agreement.

Provider Signature: _____

Witness Signature: _____ Date: _____/_____/_____

Name (Printed) _____

CURRENT MEDICATIONS

PATIENT NAME: ______________________ **DATE:** ____________________

*****Please List ALL Current Medications Including Over-The-Counter Meds*****

NAME OF MEDICINE	STRENGTH	NUMBER/DAY	REASON

Care Medical Center

2804-C N. Oak St.	162 S. Virginia Ave.	203 W. Hamilton Ave.	306 Shirley Ave.
Valdosta, Ga 31602	Tifton, GA 31794	Nashville, GA 31639	Douglas, GA 31533
P:(229)241-8925	P:(229)382-5857	P: (229)686-2277	P: (912)393-3955
F: (229)241-7672	F: (229)382-7640	F: (229)686-2099	F: (912)389-2044

AUTHORIZATION FOR RELEASE OF INFORMATION OR INDIVIDUAL ACCESS TO INFORMATION

I hereby authorize Care Medical Center to: ☐ release ☐ obtain medical information of:

_____

(Patient's Full Name)

Date of Birth:_____/____/_____ Last 4 digits of SSN: _____

I request **only** the following information to be release/obtained:

☐Emergency Report ☐Laboratory ☐Pathology Report ☐Itemized Billing Statement

☐Discharge Summary ☐Radiology Reports ☐MRI CD/Reports ☐Pain Management

☐History and physical ☐X-Rays Reports ☐Other (specify)_____

Date(s) of Treatment:_____

Requested from: Physician/Institution/Agency:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Telephone:(_____)_____:_____

ATTENTION: Once this information has been released pursuant to this Authorization, it may no longer be protected by Federal and/or State law/regulations and may no longer be deemed "Confidential". I permit the release of all information indicated above including test results and/or diagnosis and treatment information, if any, concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases.

I understand that neither Care Medical Center nor any of its affiliated health care providers can make me sign this Authorization as a condition of getting treatment, making payments on any bills, or gaining enrollment or eligibility in any health insurance plan, unless the Federal Privacy Regulations allow it. This does not apply to the billing of medical claims. I agree that I have received a signed copy of this Authorization if I choose to do it.

I understand that I may revoke this Authorization at any time except to the extent that prior action has been taken in reliance on this Authorization. This Authorization will Expire ninety (90) days from the date it is signed if I do not cancel it in writing prior to the expiration date. I understand that if I want to cancel/revoke this Authorization, I need to mail, fax, or bring the letter to the address or fax number noted at the top of this page.

If you are signing on behalf of a patient for whom you are the legal guardian or personal representative, you must attach a certified copy of your appointment as legal guardian or personal representative. If you are signing on behalf of a patient who is deceased, you must attach a certified copy of the patient's death certificate if the patient did not expire in the facility the information is being requested form.

The health care provider is neither required nor prohibited by law from engaging in private conversations regarding the patient's above-referenced care. The decision to enter into any such conversation is that of the health care provider. However, disclosure that exceeds the scope of this authorization may subject the health care provider to civil liability. This Authorization, contrary to the notice above, shall remain in effect until the underlying claim is finally resolved. Therefore, you may receive a supplemental request for documents. Provided you have an original authorization allowing you to provide records to the party making the supplemental request, a written request for supplemental documents is sufficient, and no additional authorization is required.

Note: Records will be mailed to the above address unless otherwise noted below.

_____ _____

Signature of Patient/Legal Guardian/Personal Representative **Date**

_____ _____

If someone else signs on behalf of the patient, state the relationship to Patient. **Date**

Witness:_____ _____

Date

Note: if above address is not the patient's, please complete the following:

Patient Address:_____

_____

Check if a patient will pick up copies at Care Medical Center.