James McGrath, M.D., PLLC

P.O. Box 189 | YADKINVILLE | N.C. | 27055
(336)677-1100 | (336)677-1152 - fax

JAMES MCGRATH, MD

THIS OFFICE DOES NOT PRESCRIBE CHRONIC PAIN MEDICATIONS

** By policy medical records must be transferred and reviewed by your accepting physician prior to your first visit at this practice. **

Date: _____ Staff Member Accepting Application: _____

Full Name: _____ DOB: _____

Please list all medications taken in the last 3 months:

Chronic Medical/Pain Conditions:

Past Surgical Procedures/Hospitalizations:

Last Physician Office: _____

CONTACT INFORMATION

Mailing Address: _____

_____

Phone Number: _____

Insurance information: _____

Reason For Application:

_____

_____

_____

_____

** please attach a copy of your insurance card, front and back. **

OFFICE USE ONLY:
ACCEPTED: YES NO PHYSICIAN: _____
DATE PATIENT CONTACTED: _____ INITIALS: _____
RECORDS RELEASE FAXED: _____
01132017

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AUTHORIZATION for USE or DISCLOSURE of PROTECTED HEALTH INFORM

THIS FORM MUST BE COMPLETED IN FULL

Medical Record #_____
Department Name _____
Telephone Number _____
Date Rec'd _____
Date Sent _____
Copy given to requestor (Date) _____

I hereby authorize _____ to disclose the following information from the health records of:
(Name of Provider)

Patient Name _____ Date of Birth: _____
(Person(s) or class of persons authorized to use/disclose the information)

Address _____

Telephone _____ Patient Number _____

Covering the period(s) of healthcare:

From (date) _____ to (date) _____

From (date) _____ to (date) _____

This information is to be released to _____
(Person(s) or class of persons authorized to use/disclose the information)

Description of information that may be used/disclosed: ***(The information may include medical information related to treatment of alcohol, psychiatric care, psychological assessments, substance abuse, and/or HIV/AIDS, if applicable.)***
Medical information from the most recent visit/admission to include physician notes/summaries and diagnostic results. Medical information including physician notes/summaries and diagnostic results for the periods from _____ to _____. Other: Specify information to release _____
The information will be used/disclosed for the following purposes: **Please specify the reason for this request, e.g treatment, insurance, legal, etc.**
At the request of the individual

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization to the extent allowed by law.

I understand I may revoke this authorization at any time by sending a notice of revocation in writing to the Privacy Office. I further understand that I may not revoke this authorization to the extent that action has been taken in reliance on this authorization. Information about the right to revoke has been shared with me in the James McGrath, M.D., PLLC Notice of Privacy.

This authorization expires... _____(date).

_____
Signature of Patient or Personal Representative (if applicable)

_____
Witness signature

_____
Relationship to Patient

_____ / _____
Requestor's Home Phone/Work Phone

_____ (Date)

02082017