Good Neighbor Medical Clinic

974 Ribaut Road, Beaufort, SC 29902 843-470-9088 FAX: 843-470-0299

NEW PATIENT INFORMATION

This clinic provides free medical care for patients who meet the eligibility requirements. Please review the following information to see if you qualify and to understand how the clinic works.

***Eligibility* (Elegibilidad)**

- You must live or work in or near Beaufort County.
  Usted debe vivir o trabajar en el condado norte de Beaufort o cerca de él.
- You must have NO health insurance/NO Veterans benefits/NO Medicare/ NO Medicaid.
  Usted no debe tener seguro de salud/ningún beneficio para veteranos/no Medicare/no Medicaid
- You must have income that is equal to or below 250% of the Federal Poverty Level.
  Usted debe tener ingresos iguales o inferiores al 250% del nivel federal de pobreza.
- The patient must be 18 years or older.
  Usted debe tener entre de 18 y 65 anos de edad.

Application process and Documents Required (Proceso y documentos requeridos)

- Complete ALL application forms including consent forms.
  Complete todos los formularios de solicitud incluyendo los formularios de consentimiento.
- Schedule a screening appointment by calling our office at 843-470-9088
  Programe una cita de selección. Llame la clinica (843)470-9088
- Bring in all paperwork to the screening appointment. No screening or medical appointment will be given until application is complete.
  Traiga todo el papeleo a la cita de selección. No se dará ninguna cita médica hasta que se complete la solicitud.

PHOTO ID- driver's license, passport or photo ID
ID con foto - Licencia de conducir pasaporte o identificación fotografica

PROOF OF ADDRESS OF WHERE YOU LIVE OR WORK- driver's license, utility bill or phone bill.

Comprobante de domicilio o de dónde viva o trabaje - como una licencia de conducir, factura de servicios publicos, o factura de teléfono

PROOF OF ALL SOURCES OF INCOME- ***Comprobantes de los ingresos de todo tipo***

If you have an income (*Si tiene ingresos*):

- TWO consecutive pay stubs (within the last 45 days)
- Social Security letter for current year
- Original **Disability Award Letter** OR **TPQY** form and current year SSI letter. If SSI income is from spouse, bring current year SSI letter
- Rental property income

If you do not have an income (*si no tiene ingresos*):

- If you receive SNAP benefits, please sign the enclosed consent form.
- ***Si recibe beneficios de SNAP,*** por favor firme el formulario de consentimiento adjunto

- ***DOS talones de cheques consecutivos (en los ultimos 45 dias).***

- ***Carta de seguridad social para este año***
- ***Carta original de adjudicación por discapacidad O formulario TPQY y carta de SSI del año actual. Si los ingresos de SSI son del cónyuge, traiga la carta de SSI del año actual***
- ***Renta de propiedad de alquiler***

After the eligibility requirements above have been met, you will then be scheduled for a doctor's appointment.
Despues de los requisitos de elegibilidad estan cumplidos, se le programara una cita.

Example of the 2026 Federal Poverty Level (Ejemplo del NIVEL FEDERAL DE POBREZA 2026)

SIZE OF TOTAL HOUSEHOLD (*tamaño del hogar*)	**MAXIMUM INCOME LEVEL (*ingreso maximo*)**
1	$39,900
2	$54,100
4	$82,500

GOOD NEIGHBOR MEDICAL CLINIC
APPLICATION FOR MEDICAL SERVICES
(SOLICITUD DE SERVICIOS DE MEDICINA)

Please print (por favor escribe en letras de molde)

UPDATE PROFILE TAB

DATE *(Fecha)*_____ DATE OF BIRTH *(Fecha de nacimiento)*_____

PATIENT'S NAME *(nombre del paciente)*		
LAST *(apellido)*	**FIRST *(nombre)***	**MI *(inicial)***

ADDRESS *(dirección)*	**CITY *(ciudad)***	**ZIP *(codigo postal)***

COUNTY *(condado)*	**TELEPHONE NUMBER *(telefono)***	**SOCIAL SECURITY NUMBER *(Numero de Seguridad Social)***

GENDER IDENTITY *(identidad de genero)*	**SEX ASSIGNED AT BIRTH: M or F *(sexo) Masculino o Femenino***	**MARRIED** (Casado)	**SINGLE** (Soltero)	**OTHER** (Otro)

: Race *(Raza)* CIRCLE					
AFRICAN AMERICAN	**CAUCASIAN**	**HISPANIC**	**Asian**	**Hawaiian**	**American Indian**

Ethnicity: Circle One: Hispanic or Latino Not Hispanic or Latino

Authorization to discuss Medical Information *(Authorizacion para discutir la informacion)*	**TELEPHONE NUMBER *(telefono)***	**RELATIONSHIP *(relación)***

Full name(s) of all family members (spouse and children under 18) who live with you in your house. *(Nombres completes de todos los miembros de familia (esposo & ninos menores de edad 18) que viven con usted en su casa)*		
NAME *(Nombre)*	**RELATIONSHIP *(Relación)***	**DATE OF BIRTH *(Fecha de Nacimiento)***

CONSENT TO TREAT FORM
Informed Consent bucket
Must be on File

I,_____, consent to receive medical or other services and treatment by the healthcare professional who has voluntarily agreed to provide treatment without compensation or expectation or promise of compensation as provided under section 33-35-210 of the Code of Laws of South Carolina.
Yo,_____, acepto recibir tratamiento medico asi como otros servicios y tratamientos brindados por un profecional de salud un voluntario que ha accedido a proveer el tratamiento sin una compensacion, remuneracion o promesa como se especifica en la seccion 33-35-210 de el codigo de leyes de Carolina del Sur.

Services at Good Neighbor Free Medical Clinic are offered at no charge. Please note: There may be other expenses which may include, but not limited to, outside referral fees and medications that will be your responsibility.
Los servicios en Good Neighbor Free Medical Clinic se ofrecen sin costo alguno. Por favor recuerde: que existen otros gastos, que pueden ser incluidos pero no son limitados, como ser referido a otros lugares y medicinas que correran por su cuenta.

I understand and agree that my provider is not liable for any injury, death, or other loss arising out of giving me these health care services unless injury, death or other loss is caused by my provider's gross negligence.
Yo entiendo y acepto que mi proveedor de salud no es resposable por ningun dano, muerte, o perdida resultante de los servicios de salud recibidos a menos que el dano, perdida o muerte sea causa de negligencia de mi proveedor de salud.

The Good Neighbor Free Medical Clinic gave me this notice and I signed it before receiving any health care services.
La Good Neighbor Free Medical Clinic me ha dado esta forma y yo la he firmando antes de recibir los servicios de cuidado de salud.

Patient's Name (Print Name in full): ***Nombre del Paciente (Completo):***	**Date:** ***fecha:***
Patient's Signature: ***Firma del Paciente:***	
Patient's Authorized Representative:	**Legal Relationship of Patient:**

HIPAA COMMUNICATION AUTHORIZATION

Authorization bucket
Must Be on File

I, _____, request that GNMC contact me in the following way(s) (check all that apply):
Solicito que GNMC se comunique conmigo de la siguiente manera(s) (marque todas las que correspondan):

Home (Telefono de casa): _____
__Leave a detailed message (deja un mensaje detallado)
__Leave a callback number (deja el numero de la clinica)

Cell phone (celular): _____
___Send a detailed text (enviar un texto detallado)
___Use for telemedicine (usar para la telemedicina)
___Leave a detailed voice message (deja un mensaje de voz detallado)
___Leave a callback number (deja el numero de la clinica)

Mailing address (direccion): _____
___Send mail (enviar correo)

Email (correo electronico):_____
___Send a detailed message (enviar un mensaje detallado)

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION (OPTIONAL) Information to be given to:
Autorización para discutir la información médica (opcional) Se puede dar informacion a:

NAME(Nombre): _____RELATIONSHIP (Relacion): _____

PHONE NUMBER (telefono): _____

Description of the specific information to be discussed (Descripción de la información especifica a discutir):

___Appointment date/time (fecha/hora de la cita)

___ Diagnosis (diagnóstico)

___ X-ray results (resultados de x-ray)

___ Medications (medicamentos)

___ Lab results (resultados de laboratorio)

___ Summary of medical record (resumen de historial medico)

___ Care plan (plan de cuidado)

___ All (todo)

This authorization shall remain in effect from the date signed below until (**please check one**):
Esta autorizacion permanecera en vigor desde la facha firmada a continuacion hasta (marque una):

____UNTIL TERMINATED BY PRACTICE (Hasta que termine por la práctica)

_____SPECIFY EXPIRATION DATE (Especificar vencimiento) _____

Signature _____ Date: _____

FREE CLINIC FEDERAL TORT CLAIMS ACT (FTCA) PROGRAM

Legal bucket FTCA
Signed Annually

Patient Notice of Limited Liability for FTCA Deemed Free Clinic Volunteer Health Care Professionals, Board members, Officers, Employees and Independent Contractors

Notice to Patients

To be provided to the individual patient before health care services provided, except in emergency cases when notice may be provided as soon as the emergency as is practicable or to a parent or legal guardian when the patient lacks legal responsibility for his/her case under State Law***.***
Esta notificacion debe ser entregada al paciente en forma individual antes de ser atendido por los servicios de salud, except en casos de emergencia. Si es atentido en casos de emergencia la notificacion debera proporcionarse immediatemente despues que haya sido atendido o a los padres guardians en caso de que el paciente carezca de resposabilidad propia segun la ley de estado.

This is to notify you that under Federal law relating to the operation of free clinics, the Federal Tort Claims Act (FTCA) (See 28 U.S.C sections 1346(b), 2671-80) provides exclusive remedy for damage from personal injury, including death, resulting from the performance of medical, surgical, dental or related functions by any free clinic volunteer health care practitioner, board member, officer, employee or independent contractor who the Department of Health and Human Services has deemed to be an employee of the Public Health Service. The FTCA medical malpractice coverage applies to deemed free clinic volunteer health care practitioners, board member, officer, employee or independent contractor who has provided a required or authorized service under Title XIX of the Social Security Act (i.e., Medicaid Program) at a free clinic site or through offsite programs or events carried out by the free clinic site or through offsite programs or events carried out by the free clinic (see 42 U.S.C. sections 233 (a), (o).
Esto es para noficarle que bajo la ley federal relacionada con la operacion de clinicias voluntarias, la ley de casos federales agraviados(FTC), (2ver 28 U.S.C. 1346 (b). 2401 (b), 2671-80) prove la exclusividad de poder arreglar los danos causados a personas involucradas incluyendo muertes que hayan sido resultado de una practica medica, quirurgica, dental, o cualqier otra cosa practicada por la clinica de voluntaries en la pactica del cuidado de la salud por miembros directivos,oficiales, empleados o contratistas independientes del departamento de salud y servicios humanos que han proporcionado servicios de salud al public. Esta FTCA cobertura medica de salud aplica para dar servicios gratis en la clinica voluntaria ofrecidos por los miembros directivos, oficiales, empleados o contratistas independientes que han proveido un servicio requerido o autorizado bajo el titulo XIX del seguro social act (i.e., Programa medico) a la clinica voluntaria gratuita o por medio de programas fuera de esta clinica voluntaria (ver 42 U.S.C 233 (a). (o).

The above Federal law and other State and Federal laws including the Federal Volunteer Protection Act of 1997 may cover certain free clinic health care professionals providing health care services to patients at this free clinic.
La antes mencionada ley federal y otras leyes federales del estado incluyendo la ley federal protectora de los voluntaries act de 1997 puede cubrir ciertas clinicas gratuitas y a los profesionales proveedores del cuidado de salud y servicios a los pacientes de esta clinica.

Patient Name (Print Name in full): ***Nombre del Paciente (complete):***	**Date:** ***Fecha***
Patient's Signature: ***Firma del Paciente:***	
Patient's Authorized Representative:	**Legal Relationship of Patient:**

HIPAA ACKNOWLEDGEMENT- PATIENT PRIVACY

Legal bucket
Must be on File

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of out Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office

Nuestro Aviso de las Practicas de Confidencialidad proporciona informacion sobre como podemos utilizer y divulger los datos confidenciales de su salud. El aviso contiene una seccion de Derechos del Paciente que describe sus derechos de acuerdo a la ley. Usted tiene el derecho de tomar conocimiento del contenido de nuestro Aviso antes de firmar este consentimiento. Los terminus de nuestro Aviso pueden cambiar. Si cambiamos nuestro Aviso, useted puede obtener una copia actualizada contactandose con nuestra oficina.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
Usted tiene el derecho de solicitor que restrinjamos el uso o divugacion de los datos confidenciales de su salud para ser usados para el tratamiento, pago o operaciones de cuidado medico. No se nos require convener esta restriccion, pero si lo hacemos, lo haremos honrando este acuerdo.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
Al Firmar este acuerdo usted consiente a nuestro uso y divulgacion de los datos confidenciales de su salud para ser usados para el tratamiento, pago o operaciones de cuidado medico. Usted tiene el derecho de revocar esta consentimiento por escrito, firmado por usted. Sin embargo, tal revocacion no afectara ningun uso o divulgacion que hayamos hecho con anterioridad a la revocacion, basados en su authorizacion previa. La Clinica proporciona este formulario a fines de cumplir con el Acta de Transferibilidad y Responsabilidad del Seguro Medico de 1996 (HIPAA).

The patient understands that: *El paciente entiende que:*

- **Protected health information may be disclosed or used for treatment, payment or health care operations*. Los datos confidenciales de su salud pueden ser divulgados o utilizados para el tratamiento, pago, o operaciones de cuidado medico.***
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice*. La Clinica tiene un Aviso de las Practicas de Confidencialidad y el paciente tiene oportunidad de informarse sobre dicho Aviso.***
- **The Practice reserves the right to change the Notice of Privacy Practices. *La Clinica se reserve el derecho de cambiar el Aviso de las Practicas de Confidencialidad.***
- **The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions. *El paciente tiene el derecho de restringir el uso de su datos confidenciales pero La Clinica no tiene obligacion de consenter las restricciones.***
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease. *El paciente puede revocar este consentimiento por escrito en cualquier momento y cesara toda devulgacion future.***
- **The Practice may condition receipt of treatment upon the execution of this consent. *La Clinic puede condicionar el suministro de tratamiento a la firma de consentimiento.***

THE CONSENT WAS SIGNED BY:

Patient's printed name/ Letra imprenta- Paciente | Date/Fecha

WITNESS:

Printed Name- Practice Representative | Date

CLINIC RULES

reglas de la clinica

to be signed at the time of screening

Clinic Paperwork bucket
Must be on File

	Patient's Initials	Screener's Initials
1. All medications will be brought to all appointments. ***Todos los medicamentos se llevarán a todas las citas.***		
2. Patient is responsible for confirming or cancelling appointments 24 hours prior to appointment. ***El paciente es responsable de confirmar o cancelar citas 24 horas antes de la cita.***		
3. Clinic may reschedule appointments if patient is more than 20 minutes late or hasn't confirmed an appointment. ***La clínica puede reprogramar citas si el paciente tiene más de 20 minutos de retraso o no ha confirmado una cita.***		
4. If you miss 3 scheduled appointments without calling to cancel (no show) within a 12 month period, you will not be able to receive services from GNFMC for 6 months. ***Si no te presentas a 3 de su citas, sin hablar para cancelar la cita. No va poder recibir servicios de GNFMC por un periodo de 6 meses.***		
5. Patient will inform GNFMC promptly if insurance is obtained (Medicare, Commercial Insurance, VA benefits, etc). ***El paciente informará GNFMC puntualmente si se obtiene un seguro.***		
6. Abusive behavior, physical or oral, may result in permanent dismissal from the clinic. ***Comportamiento abusivo, físico u oral, puede resultar en despido permanente de la clínica.***		
7. Prescription refills require 24-48 hour notice to fill. ***Las renovaciones de recetas requieren un aviso de 24 a 48 horas para completar.***		
8. No food is permitted in the clinic waiting area. ***No se permiten alimentos en el área de espera de la clínica.***		
9. Cell Phones need to remain on silent mode while in the clinic. ***Los teléfonos celulares deben permanecer en modo silencioso mientras se encuentran en la clínica.***		

10. Beaufort Memorial Hospital emergency services or the Pratt Emergency Department are not covered by Good Neighbor Medical Clinic.

Patient Initial: _____

I have read and understand the above information and consent to comply with eligibility requirements and rules.

Patient's Name (printed):_____Date: _____

Patient's Signature: _____

MEDICAL HISTORY / *HISTORIAL MEDICO*

Name/*Nombre y apellidos*:_____ **Date of Birth / *Fecha de nacimiento***: _____

Medications / *Medicamentos*:

1)	4)	7)
2)	5)	8)
3)	6)	9)

Allergies / *Alergias (*List food or medication and type of reaction/*enumere alimentos o medicamentos y el tipo de reacción)*:

_____ _____ _____

_____ _____ _____

Surgical History / *Cirugia*:

Date / *Fecha*	Surgery / *Tipo*	Place / *Lugar*
1)		
2)		
3)		

Recent Hospitalizations / *Hospitalizaciónes recientes*: 2) _____ 3) _____

Date / *Fecha*	Reason / *Razón*	Place / *Lugar*
1)		
2)		
3)		

Preventative Care or Screenings / atencion preventiva o examenes de deteccion:

	Yes or no (si o no)	Date / *Fecha*	Place / *Lugar*
1) MRI, CT, or similar test			
2) Colonoscopy			
3)			

Past Medical History (have you ever had the following, circle yes or no):

High blood pressure.....yes no Diabetes.....yes no
Asthma or emphysema.....yes no Heart Disease.....yes no
Depression or anxiety.....yes no Headaches.....yes no
Chronic pain.....yes no HIV/AIDS.....yes no
Mental disorder or illness..yes no Thyroid disease.....yes no
Addiction (alcohol/drugs)..yes no Tuberculosis.....yes no
Epilepsy or seizures.....yes no Vision problems.....yes no
Hearing problems.....yes no

Cancer.....yes no
-Type:_____
-Date of diagnosis:_____
Blood transfusion.yes no
Hepatitis.....yes no
Stroke..... yes no

Other medical conditions (please list):

_____

_____

Historial medico anterior (alguna vez ha tenido lo siguiente, marque si o no):

Hipertension.....si no
Asma o enfisema.....si no
Depresi6n o ansiedad..... si no
Dolor cr6nico.....si no
Trastorno/enfermedad mental....si no
Adicci6n (alcohol/drogas)..... si no
Epilepsia o convulsiones.....si no
Problemas de audici6n.....si no

Diabetes.....si no
Enfermedad del corazon....si no
Dolores de cabeza....si no
VIH / SIDA.....si no
Enfermedad de tiroides...si no
Tuberculosis.....si no
Problemas de vista.....si no

Cancer.....si no
-Tipo:_____
-Fecha de diagnostico:
_____
Transfusion de sangre.....si no
Hepatitis.....si no
Accidente cerebrovascular....si no

Otras condiciones (enumere):
_____
_____

Family History / *Historial Familiar*:

	Living or Age at Death / *Vivo o la edad al morir*	**Conditions:** (ex. diabetes, high blood pressure, cancer, heart disease, etc.) ***Condiciones: (por ejemplo la diabetes, problemas cardiacos, el cancer, etc.)***
Father/***Padre***		
Mother/***Madre***		
Brother/***Hermano***		
Sister/***Hermana***		
Child/***Hijo o hija***		
Other/***Otros***		

Social History / *Historial Social:*

	Type/ *Tipo*	**Amount/ *Cantidad***	**Current User /*Uso Actual***	**Former User/ *Uso Anterior***	**How Long/ *Por Cuánto Tiempo***
Tobacco/***Tabaco:***					
Alcohol:					
Other Drug Use/ ***Otras Drogas***:					

Ob/Gyn History (women only) // *Historia de obstetricia / ginecologia (solo mujeres)*
Number of pregnancies (***Numero de embarazos***)_____Live births ***(Nacidos vivos)***_____
Miscarriages ***(Abortos espontaneos)***_____Abortions ***(Abortos)*** _____
Current method of birth control ***(Método actual de contracepción)***_____
Age at menopause, if reached ***(Edad de la menopausia, si corresponde)*** _____
Date of last Pap smear ***(Fecha de la ultima prueba de Papanicolaou)*** _____
Date of last mammogram ***(Fecha de la ultima mamograffa)***_____

Previous Primary Care Providers *(Proveedores de atención primaria anteriores)*

Name ***(Nombre)***	Address ***(Direccion)***	Phone No. ***(Telefono)***	Dates under care ***(Fechas bajo cuidado)***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Immunizations (last year received) ***Vacunas y el último año recibido***
Flu *(Gripe)* _____ Tetanus (Tdap) ___ Pneumonia 1 or 2?*(neumonía 1 o 2?)*___Chicken Pox *(Varicela)*_____
Hepatitis A ____ Hepatitis B_____HPV _____ Shing es (*herpes*}_____COVID_____ Other (Otros}_____

I confirm that all information provided is correct.
Confirmo que la información proporcionada es correcta

Signature _____
Firma _____

Good Neighbor Medical Clinic

Authorization for the release of confidential Information

Must be on File

GNMC Medical Release for Partners

Name:_____Date of Birth_____

SS#_____

The undersigned hereby authorizes Good Neighbor Free Medical Clinic to release confidential information to one or more of the following: Collaborative partners for treatment and medical care, Beaufort Memorial Hospital, Department of Social Services, SC Vocational Rehab, SC Employment Commission, Social Security Administration, DHEC, Med-I-Assist, AccessHealth, Coastal Empire Mental Health Center, Welvista and offices of physicians or providers for whom I have or will receive care.

Type of information disclosed: enrollment in, participation in, and care progress and past or present medical or other information about you and your family to assist you in obtaining placement for medical or community care and/or services. This information may include, but is not limited to, any history of psychiatric care, sexual assault or tests for infectious diseases including AIDS/HIV. By signing below, you also agree to the release of medical or other information about you to state and/or federal governmental regulatory agencies as may be required by law.

The purpose of the release of confidential information: to facilitate achievement of your care goals. Being in the program is voluntary, and I understand that I may leave the program at any time and revoke this authorization to release medical and other information at any time by mailing or delivering a written revocation to the following address: AccessHealth Lowcountry. ATTN: Director, 955 Ribaut Road. Beaufort, SC 29902 or Good Neighbor Free Medical Clinic, 974 Ribaut Road, Beaufort, SC 29902.

I understand that I may refuse to sign this authorization. I understand that my information is protected under the Health Insurance Portability and Accountability Act of 1996(HIPPA) federal regulations on patient privacy and confidentiality, and cannot be disclosed without my written consent unless otherwise provided for by applicable law. I am entitled to review or receive a copy of the information for which the authorization is being sought. I will receive a copy of the signed authorization. I may revoke this consent in writing at any time. This authorization expires:

___upon termination from the practice, or: _____

(Specify event or condition)

_____ _____

(Signature) (Date)

_____ _____

(Witness Signature) (Date)

Good Neighbor Medical Clinic

Fax: 843-470-0299 Phone: 843-470-9088

MRN: _____

ROI Status: q Processed q Returned to Requester q Encounter

q Chart Review q Return Letter Date: _____

q Document(s) released in accordance with scope of patient request

Date records were provided: _____

GNMC Release Authorization of Medical Information

Authorization bucket - Initial to Obtain Records; Annually if New Records are to be Obtained

Please read all information and instructions before completing and signing the authorization form.

Patient's Name_____Birth date _____
(Please Print) LAST FIRST MI

Are medical records filed under another name?_____Phone Number _____

INFORMATION TO BE RELEASED ***BY:***	INFORMATION TO BE RELEASED ***TO:***
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	**REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**
Organization/Person Name	Organization/Person Name
Street Address City, State, Zip	Street Address City, State, Zip
Phone Fax	Phone Fax

TYPE OF MEDICAL INFORMATION REQUESTED:

q Complete medical record abstract (includes 3 years of chart notes, most recent labs/pathology & diagnostic imaging reports)
q Cancer Partnership records q Radiology/ Diagnostic Imaging (CD/Films) q Mammogram Diagnostic Imaging (CD/Films)
q Echocardiograms q Pharmacy q Behavioral Health records only
q My health information relating only to the following treatment or condition: _____
q My health information only for the following date(s): _____
q Other:_____

REASON FOR REQUEST: q Personal q Transfer of Care q Disability q Insurance q Legal Review q Continuing Care
q Other (please explain):_____

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 services, and treatment for alcohol and drug abuse or self-paid services. You are hereby specifically authorized to release all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

_____

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).

Patient signature_____Date _____

Parent or Legal Guardian_____Date _____

Relationship to patient, if other than patient_____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is NOT sufficient. 42 CFR Part 2: RCW 70.02.300