NEPHROLOGY ASSOCIATES OF MOBILE, P.A.

917 A Plantation Boulevard

Fairhope, Alabama 36532

R. Michael Huddle, MD
Philip J. Butera, MD, FACP
Philip S. Travis, MD
Ronald L. Gaines, MD
Douglas A. Amare, MD
Maryella D. Sirmon, MD, FACP
J. Michael Nipper, MD
M. Craig Kleinmann, DO

Mailing Address:
Post Office Box 850849
Mobile, Alabama 36685-0849

Telephone: 251.990.3533

Facsimile: 251.990.9942

Stephen P. Wilber, MD
W. Bibb Lamar, MD
Christopher Mire, MD
F. Duncan Scott, MD
Jonathan B. Cole, MD
R. Sellors Meador, MD
Connie Andrews, CRNP
Christine Avinger, CRNP

Dear Patient,

Thank you for entrusting your care to one of the physicians of Nephrology Associates of Mobile, P.A. We are committed to providing you the highest quality of care possible at all times, including insuring that you are able to see your physician at the time of your appointment in a timely manner.

To do that, we will need your assistance. Because you are a new patient, we need to gather information about you, your medical history, your insurance and other related information. Enclosed you will find forms designed to provide the information we need to insure that we deliver the care that you deserve. ***Please take some time to complete these forms before you arrive for your first appointment.*** By doing so, you will help us to timely complete your chart for your physician. Please also bring the following with you:

- Insurance cards & PHOTO ID
- **COPAYMENT REQUIRED AT THE TIME OF THE VISIT**
- Prescription cards, if any, and
- All of your current medications
- IF no insurance, you will require to pay $50.00 for the first visit **at the time of the visit,** and $30.00 **each visit thereafter.**

Failure to bring the items mentioned above will at best delay your appointment or could possibly result in our office having to reschedule your appointment.

According to our records, your appointment is on _____ at _____. We ask that you arrive at _____, ***(30 minutes prior to your appointment time)*** so we can perform a final check on your required paperwork.

Our office is open from 8:00 a.m. to 4:30 p.m., Monday through Friday. Please do not hesitate to contact us with any questions. We ask that you call at least 24 hours in advance of any appointment should you need to reschedule your appointment.

Again, thank you for entrusting your care to us. Our staff is ready to assist you in any way possible to provide you excellent care.

NEPHROLOGY ASSOCIATES OF MOBILE, P.A.
917-A Plantation Blvd.
Fairhope, Alabama 36532

R. Michael Huddle, MD
Philip J. Butera, MD, FACP
Philip S. Travis, MD
Ronald L. Gaines, MD
Douglas A. Amare, MD
Maryella D. Sirmon, MD, FACP

Mailing Address:
Post Office Box 850849
Mobile, Alabama 36685-0849

Telephone: 251. 990.3533

Toll Free: 888.297.9777
Facsimile: 251.990.9942

J.Michael Nipper, MD
M. Craig Kleinmann, DO
Stephen P. Wilber, MD
W. Bibb Lamar, MD
Christopher Mire, MD
F. Duncan Scott, MD

Appointment Reminders

At Nephrology Associates of Mobile, P.A. we are committed to providing you excellent patient care. A part of that commitment is our telephone reminder system – HouseCalls.

HouseCalls is an automated system that will call you both one week in advance and the day before your next scheduled appointment. The purpose of the system is to remind you to have any lab work or tests completed to insure that your physician has the information needed to provide you excellent care.

Please listen carefully when you receive your call as you will be asked to confirm or reschedule your next appointment. It important that you respond to the prompts as we receive a daily report of the calls made from the evening before and we review the report to insure that our schedule is correct. If you are unavailable when the system calls the system will leave a reminder message on your answering machine if one is available.

Thank you for choosing Nephrology Associates of Mobile, P.A. Our staff is ready to provide the assistance you need to receive excellent care. Call us with questions at Monday through Friday from 9:00 a.m. to 4:30 p.m. at 251.990.3533

Nephrology Associates
Dr. Douglas Amare
Dr. Christopher Mire

Fairhope Office Directions
917-A Plantation Blvd.
Fairhope, Al 36532
251-990-3533

We are located across Hwy 98 from McDonald's in Fairhope in Homestead Village. We are the 6th building on the left on Plantation Blvd.

Foley Office Directions
230 East Fern Ave.
Foley, Al 36535
251-943-4300

Traveling North on Hwy 59, you will need to turn right at the red light before South Baldwin Regional Medical Center onto Fern Ave. (There is a Shell gas station located on the left at the light.)

We are located inside Foley Dialysis clinic, which is the only building on the right on Fern Ave., 1st door on the left inside the clinic.

*****Please be able to provide us with a urine specimen at this appointment, cup will be provided for you at the office.**

Please call if you should have any questions…

PLEASE COMPLETE AND RETURNTO THE FRONT DESK ALONG WITH YOUR DRIVER'S LICENSE AND INSURANCE CARDS

PATIENT INFORMATION -- PLEASE PRINT

Patient Number _____ Date _____

Last Name _____ First Name _____ Middle Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security Number _____ Date of Birth _____

Place of Employment _____ Work Phone _____

Marital Status _____ Spouse's Name _____

Primary Insurance Company _____ Policy Number _____

Secondary Insurance Company _____ Policy Number _____

Co-pay (if any) _____ ☐ Yes ☐ No Referral Required?

Primary Care Physician (if any) _____ Phone Number _____

Assigned Hospital (if any) _____ Phone Number _____

EMERGENCY CONTACT – DOES NOT LIVE IN YOUR HOME

Name _____ Relationship _____ Phone Number _____

Date Updated _____ By _____

TO MA:

Name _____ Date of Birth _____

Primary Care Doctor _____ Referring Doctor _____

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE

Medication Name	mg / mcg	How Often You Take It

DRUG ALLERGIES OR MEDICATIONS THAT YOU CANNOT TAKE

Medication Name	Reaction

Pharmacy Name	Address	Phone Number
Local _____		
Mail Order _____		
Other _____		

Patient Name: _____ Date of Birth: _____

Family and Social History

Ethnic Background	___ African American	___ Native American
	___ Alaskan Native	___ Pacific Islander
	___ Asian	___ White
	___ Latino	___ Other/Would Rather Not Say
Religion	___ Baptist	___ Muslim
	___ Catholic	___ Protestant
	___ Jewish	___ Other/Would Rather Not Say
Marital Status	☐ Single	
	☐ Married	Spouse's Name _____
	☐ Divorced	
	☐ Separated	
	☐ Widowed	
	☐ Other	
Next of Kin	_____	
Smoking	☐ Current Every Day Smoker	Packs/Day ___ for ___ years
	☐ Current Some Day Smoker	
	☐ Former Smoker	
	☐ Never Smoker	
Alcohol	☐ Never Used Alcohol	
	☐ Occasional Social Drinker	1-3 Drinks/Day ___
		3 or More/Day ___
	☐ Quit Using Alcohol	
Drug Use	☐ Never Used Illegal Drugs	
	☐ Prior/Current Illegal Drug Use	

Past Family Medical History

Family History of Renal Disease ☐ Yes ☐ No

REVIEW OF SYSTEMS

CONSTITUTIONAL

WEIGHT CHANGE Of More Than 15 Pounds In Last 3 Months	☐ YES	☐ NO

HEENT

LASER TREATMENT To Eyes For Diabetes	☐ YES	☐ NO
HEARING LOSS	☐ YES	☐ NO

RESPIRATORY

RECENT PNEUMONIA	☐ YES	☐ NO

CARDIOLOGY

PALPITATIONS (HEART FLUTTERING)	☐ YES	☐ NO

GI

HEMATEMESIS (VOMITING BLOOD)	☐ YES	☐ NO

GI

RENAL STONES	☐ YES	☐ NO

HEMATOLOGY/LYMPH

PROLONGED BLEEDING OF SKIN	☐ YES	☐ NO
BLOOD CLOTS IN LEG VEINS OR LUNGS	☐ YES	☐ NO
H/O CANCER	☐ YES	☐ NO

DERMATOLOGY

CHRONIC OR NEW SKIN CHANGES	☐ YES	☐ NO

NEUROLOGY

SEIZURES	☐ YES	☐ NO
DEMENTIA	☐ YES	☐ NO

PSYCHIATRIC DIAGNOSIS	☐ YES	☐ NO

PROBLEM LIST SURVEY

NEUROLOGY

STROKE ☐N ☐Y ABOUT WHEN:_____ DR._____
TIA ☐N ☐Y ABOUT WHEN:_____ HOSPITAL_____
SEIZURES ☐N ☐Y ABOUT WHEN:_____ DR._____

ENT

CATARACTS ☐N ☐Y When Removed _____ Doctor _____
GLAUCOMA ☐N ☐Y _____
OTHER EYE PROBLEMS:_____

ENDOCRINE

DIABETES SPECIALIST NAME
STARTED TABLETS ABOUT_____YEAR DR._____
STARTED INSULIN ABOUT_____YEAR DR._____
THYROID DZ
STARTED MEDICINE ABOUT_____YEAR DR._____
ADRENAL/OTHER: ☐N ☐Y _____

LUNG

ASTHMA ☐N ☐Y DR._____
EMPHYSEMA ☐N ☐Y
CANCER/OTHER ☐N ☐Y

HEART

DR._____

HIGH BP	☐N	☐Y	STARTED ABOUT_____YEAR	
HEART FAILURE	☐N	☐Y	STARTED ABOUT_____YEAR	
	☐	☐		HOSPITAL
HEART ATTACK	☐N	☐Y	ABOUT_____YEAR	_____
(LAST) HEART CATH.	☐N	☐Y	ABOUT_____YEAR	_____
BALLOON	☐N	☐Y	ABOUT_____YEAR	_____
STENT	☐N	☐Y	ABOUT_____YEAR	_____
CABG/BYPASS	☐N	☐Y	ABOUT_____YEAR	_____
HEART VALVE SURGERY	☐N	☐Y	ABOUT_____YEAR	_____
PACEMAKER	☐N	☐Y	ABOUT_____YEAR	_____
DEFIBRILLATOR	☐N	☐Y	ABOUT_____YEAR	_____

GI

DID SOMEONE EVER LOOK INTO
YOUR STOMACH WITH A SCOPE/TUBE ☐N ☐Y
IF YES WHY:_____ DR._____
WHEN:_____ HOSPITAL_____
FINDINGS:_____

PROBLEM LIST SURVEY (CONT'D)

DID SOMEONE EVER LOOK INTO
YOUR LOWER INTESTINE WITH A SCOPE/TUBE ☐N ☐Y
IF YES WHY: _____ DR. _____
WHEN: _____ HOSPITAL _____
FINDINGS: _____

GI

SPECIALIST NAME

GALLSTONES ☐N ☐Y DR. _____
TREATED WITH SURGERY ☐N ☐Y HOSPITAL _____
LIVER DISEASE
HEPATITIS ☐N ☐Y TYPE _____
CIRRHOSIS ☐N ☐Y
CAUSED BY: _____
PANCREAS PROBLEM ☐N ☐Y
CHRONIC DIARRHEA ☐N ☐Y
CANCER ☐N ☐Y ABOUT WHEN: _____ DR. _____
TYPE: _____ HOSPITAL _____
OTHER PROBLEMS: _____

GU-GYN
PROSTATE PROBLEMS ☐N ☐Y DR. _____
SURGERY ☐N ☐Y
FOR CANCER ☐N ☐Y ABOUT WHEN: _____ HOSPITAL _____
OTHER PROBLEMS: _____
HYSTERECTOMY ☐N ☐Y ABOUT WHEN: _____ DR. _____
FOR CANCER ☐N ☐Y HOSPITAL _____
OTHER PROBLEMS: _____

HEME/LYMPH
BLEEDING PROBLEMS ☐N ☐Y HOSPITAL/DR. _____
BLOOD CANCER ☐N ☐Y ABOUT WHEN: _____
TYPE: _____

MUSCULO-SKELETAL
RHEUMATOID ARTHRITIS ☐N ☐Y DR. _____
LUPUS ☐N ☐Y DR. _____
OTHER: _____
JOINT REPLACEMENTS ☐N ☐Y DR. _____
SITES: _____

SKIN
CANCER ☐N ☐Y DR. _____
OTHER: _____

Medicare Part B

Extended Patient Signature Authorization

TO BE COMPLETED BY PROVIDERS OF SERVICE – Please print or type

Provider's Name (*If you are a DMA supplier, please complete certification at bottom of page*)	Provider's I.D.Code
Provider's Address (*Street, City, State, ZIP Code*)	

Beneficiary's Name	Medicare HI number	Applicable MEDIGAP Group Number

TO BE COMPLETED BY BENEFICIARY OR AGENT – Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICAL BENEFITS	***I request that payment of authorized Medicare benefits be made on my behalf to Dr. H,B,T,G,A, S,N,K,W,L,M, DS or to Nephrology Associates of Mobile, P.A. (the Supplier) for any services or items furnished to me by the physician or supplier, I authorize any holder of medical information about me to release to Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.***
********** STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS	***I request that payment of authorized MEDIGAP benefits be made on my behalf to Nephrology Associates of Mobile, P.A. for any services furnished to me by the physician/ supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP Insurer)_____ any information needed to determine these benefits or the benefits payable.***

_____ _____
Signature of Beneficiary or Person Signing for Beneficiary — Date Signed

Address of Person Signing for Beneficiary (*Street, City, State, ZIP Code*)	Relationship of Agent to Beneficiary

Reason Beneficiary Is Unable To Sign

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment – **even those in which the physician has not accepted assignment.**
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients. **"DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF."** This requirement is necessary to prevent patient from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. **Only use this extended patient signature request for assigned claims.**
2. **Renew the patient signature agreement if a new item is rented or purchased.**
3. **Place alongside the beneficiary's signature the following statement. "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."**

DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNED CASES.

This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.

_____ _____
Signature of Durable Medical Equipment Supplier — Date Signed

NEPHROLOGY ASSOCIATES OF MOBILE, P.A.

917 Plantation Blvd
Fairhope, Alabama 36532

R. Michael Huddle, MD
Philip J. Butera, MD, FACP
Philip S. Travis, MD
Ronald L. Gaines, MD
Douglas A. Amare, MD
Maryella D. Sirmon, MD, FACP

Mailing Address:
Post Office Box 850849
Mobile, Alabama 36685-0849

Telephone: 251.990.3533

Toll Free: 888.297.9777
Facsimile: 251.990.9942

J.Michael Nipper, MD
M. Craig Kleinmann, DO
Stephen P. Wilber, MD
W. Bibb Lamar, MD
Christopher Mire, MD
F. Duncan Scott, MD

ASSIGNMENT OF INSURANCE BENEFITS

I do hereby authorize payment of all benefits, basic and major medical, to be made directly to Nephrology Associates of Mobile, P.A. I also agree to pay for services I receive that are not covered by my medical insurance as well as for any deductible or co-payment due at the time of service.

_____ _____

Signed Date

CONSENT FOR TREATMENT

Knowing that I am suffering from a condition requiring diagnosis and/or medical treatment, do hereby voluntarily consent to such diagnostic procedures, hospital care, examinations, and treatment as are necessary in the judgment of the physician(s) in charge of my care.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me in the results of examination or treatment in the hospital or office. I hereby authorize Nephrology Associates of Mobile, P.A. to retain or dispose of any specimens that may be taken during examinations or treatment.

_____ _____

Signed **Date**

_____ _____

Authorized Representative **Relationship**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I give permission to Nephrology Associates of Mobile, PA to submit full medical records, within discretion, to my insurance companies if they so request and to other physicians that I am consulting if they so request.

_____ _____

Signed Date Signed

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Nephrology Associates of Mobile, PA, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Nephrology Associates of Mobile, PA's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have received the practice's Notice of Privacy Practices prior to signing this consent. Nephrology Associates of Mobile, PA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Nephrology Associates of Mobile, PA, P.C Privacy Officer at 4682 Airport Boulevard, Mobile, Alabama 36608.

With my consent, Nephrology Associates of Mobile, PA, may share my protected health information (PHI) with the following individuals: **(please list family or friends)**

_____

_____

With my consent, Nephrology Associates of Mobile, PA call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Nephrology Associates of Mobile, PA, may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

By signing this form, I am consenting to Nephrology Associates of Mobile, PA's use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, Nephrology Associates of Mobile, PA may decline to provide treatment to me.

_____ _____

Signed DATE

EFFECTIVE DATE April 1, 2003

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PEASE REVIEW IT CAREFULLY

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within on of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy or other persons who are a part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected health information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners; medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donations; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures"." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny you request for an amendment.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment and health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the practice's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Harry Bishop, Clinic Administrator, 251.343.5004. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.

If you have any questions about this notice or would like to receive a more detailed explanation, please contact the Privacy Officer.

Patient Signature Date Signed

Patient Representative Signature Relationship to Patient

NEPHROLOGY ASSOCIATES OF MOBILE, P.A.
917-A PLANTATION BOULEVARD
Fairhope, Alabama 36532
Douglas A. Amare, MD
Telephone: 251.990.3533
Facsimile: 251.990.9942
Christopher Mire, MD

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ SS#: _____

I authorize _____ to use and/or disclose certain protected health information (PHI) about me to:

_____

_____

_____

The following information will be for the period of: _____

This authorization permits _____ to use and/or disclose any health information including drug and/or alcohol use, mental health and sexually transmitted diseases, including HIV.

Information will be used or disclosed for the following purpose: _____

_____

I understand that I can revoke this authorization at any time except to the extent that any action has been taken in reliance on this authorization. I understand that I must submit my request in writing to the Privacy Officer.

This authorization will expire in one (1) year from the date signed below unless specifically stated otherwise. Date of expiration, if different: _____

I understand that I am not required to sign this form in order to receive treatment.

_____ _____

Signature of Patient Date

_____ _____

Signature of Authorized Representative Date