Authorization for Disclosure of Confidential Information

(CONFIDENTIAL INFORMATION)

Patient's Full Name:		
Address:		
City:	State:	Zip Code:
DOB:	Age:	Social Security No.:

I request and authorize (Physician/Facility): ______________________________

Address: ______________________________

City, State, Zip: ______________________________

to release the following information to: **East Lake Medical, PLLC**

Address: 11980 STATE HWY 64 E SUITE G

City, State, Zip: TYLER, TEXAS 75707

This request and authorization applies to: (Check all that may apply)

- ☐ History
- ☐ Lab Reports
- ☐ Operative Report
- ☐ Psychological Reports
- ☐ Physical
- ☐ X-ray
- ☐ Care Plan
- ☐ All Records
- ☐ Progress Notes
- ☐ EKG Report
- ☐ Therapy Reports
- ______________________________

For the purpose of: ☐ Medical Care ☐ Insurance ☐ Attorney ☐ Other

Please fax all records to 903-650-8576

I understand that my express consent is required to release any health care information if I have been tested, diagnosed, and/or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

______________________________ SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED REPRESENTATIVE

______________________________ DATE SIGNED

Relationship to patient, if not patient: ______________________________

NOTE: THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE 90 DAYS FROM THE DATE OF MY SIGNATURE UNLESS OTHERWISE REVOKED AS SPECIFIED ABOVE.

ANY DISCLOSURE OF MEDICAL INFORMATION BY THE RECEIPIENT(S) IS PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.

Patient Information

Patient's Full Name:		
Address:		
City:	State:	Zip Code:
DOB:	Age:	Social Security No.:

Male______ Female______

Phone Number ____________________

Email Address: ____________________

Driver's License (State, Number): ____________________

Race: __________ Ethnicity: __________

Emergency Contact

Full Name ____________________

Relationship ____________________

Phone Number ____________________

Address ____________________

Preferred Pharmacy: ____________________

Phone Number: ____________________

East Lake Medical, PLLC May contact me via:

Circle all that apply:

Email Text Portal Phone

Patient Health Questionnaire

Patient Name: ______________________________

This questionnaire is intended to establish a number of basic health facts which are important to the analysis of your problem(s) and to gain a comprehensive picture of your health. It is not intended to substitute for a personal interview, but rather to ensure that as much time as possible will be spent discussing the problems that concern you.

CHIEF COMPLAINT: (Briefly describe your main reason(s) for coming to the doctor today)

____

____

Other Medical Problems: ______________________________

____

____

Childhood Illnesses: ______________________________

Previous Surgeries: (Include dates) ______________________________

____

____

SOCIAL HABITS:

A. Habits:

Do you smoke/Vape? ☐ Yes ☐ No How much? ______________ How long? ______________

Do you drink alcoholic beverages? ☐ Yes ☐ No How often/long?: ______________

Do you drink coffee/tea? ☐ Yes ☐ No How much? ______________

Do you follow a particular diet? ☐ Yes ☐ No If so, for what reason? ______________

Do you exercise regularly? ☐ Yes ☐ No What kind? ______________ How often/long? ______________

A. Occupation:

What kind of work do you do? ______________________________

How long? ______________ Hours per week? ______________ Are you satisfied? ☐ Yes ☐ No

Are you aware of any hazardous exposures or other health problems associated with your present or past employment? ☐ Yes ☐ No If yes, what? ______________

Have you changed jobs for health reasons? ☐ Yes ☐ No Served in the military? ☐ Yes ☐ No

Have you received Worker's Comp. or other disability? ☐ Yes ☐ No

A. Personal:

Highest level of education? ☐ High School ☐ College ☐ Technical/Business

Hobbies you enjoy: ______________________________

Where were you born? ______________ Where else have you lived? ______________

A. Family History: Please list any family member with major health problem(s) and specify the problem(s)

☐ Father: ______________________________

☐ Mother: ______________________________

☐ Siblings: ______________________________

MEDICATION:

Allergies: ______________________

Reactions: ______________________

Current Meds/Reasons: ______________________

Date(s) of last immunization(s): ______________________

RECENT DIAGNOSTIC STUDIES: Please give date(s)

X-Ray (specify type): ______________________

EKG: ______________________

Pap Smear: ______________________

Mammogram: ______________________

Pulmonary Functions: ______________________

GI Series: ______________________

Proctoscopy/Colonoscopy: ______________________

Dental Work: ______________________

REVIEW OF SYSTEMS: Please check any of the problems below that you have now or had recently.

- ☐ Ear/Hearing trouble
- ☐ Visual/ Eye difficulties
- ☐ Nasal/Sinus trouble
- ☐ Teeth/Gum problems
- ☐ Persistent hoarseness
- ☐ Coughing up blood
- ☐ Difficulty swallowing
- ☐ Frequent, severe cough
- ☐ Pain, or lumps in neck
- ☐ Chest pain/Tightness
- ☐ Racing heartbeat
- ☐ Shortness of breath
- ☐ Stomach pain
- ☐ Nausea, vomiting
- ☐ Heartburn, gas, belching, bloating
- ☐ Use marijuana or hard drugs
- ☐ Poor or excessive appetite
- ☐ Marked weight change
- ☐ Constipation/Diarrhea
- ☐ Rectal pain, bleeding, itching
- ☐ Painful or frequent urination
- ☐ Blood in urine
- ☐ Vaginal discharge/Menstrual Problems
- ☐ Breast pain or lumps
- ☐ Take birth control pills
- ☐ Joint pain, swelling, stiffness
- ☐ Muscle pain, weakness
- ☐ Feet/ankle swelling
- ☐ Blackout spells
- ☐ Dizziness
- ☐ Frequent or severe headache
- ☐ Other ______________________
- ☐ Difficulty sleeping
- ☐ Depression/crying spells
- ☐ Excessive worry
- ☐ Frightening thoughts/dreams
- ☐ Loss of memory or concentration
- ☐ Work or family problems
- ☐ Desire psychiatric help
- ☐ Fever or chills
- ☐ Painful testicles
- ☐ Sexual problems
- ☐ Skin problems, change in mole
- ☐ Severe, persistent itching
- ☐ Numbness, tingling
- ☐ Severe fatigue
- ☐ Trembling, shaking

Consent to Treat Form

1. I____________ give permission for East Lake Medical, PLLC to give me medical treatment.

2. I allow East Lake Medical, PLLC to file for insurance benefits to pay for the care I receive.

I understand that:
• East Lake Medical, PLLC] will have to send my medical record information to my insurance company.
• I must pay my share of the costs.
• I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
• I have the right to refuse any procedure or treatment.
• I have the right to discuss all medical treatments with my clinician.

Patient's Signature ____________________________________
Date

Parent or Guardian Signature_____________________________
Date
(for children under 18)

Print name ____