PATIENT INFORMATION

Date ___/___/___

Name: Last _____ First _____ Middle Initial _____
Address _____
City _____ State _____ Zip _____
Home Phone (____) _____-_____ Cell Phone (____) _____-_____
Work Phone (____) _____-_____ Ext. _____ Email Address _____
Previous Primary Care Doctor _____
Who referred you _____
Date of Birth ____/____/____ Gender F M Social Security # _____-____-_____
Marital Status: Single Divorced Legally Separated Partner Married Widowed
Employer Name: _____ Address: _____
Employment/Student(circle one): Full Time Not Employed Retired
Part Time Active Military Self Employed
Full Time Part Time Not a Student

Emergency Contact:
Name: Last _____ First _____Relation _____
Address _____
City _____ State _____ Zip _____
Home Phone (____) _____-_____ Cell Phone (____) _____-_____
Work Phone (____) _____-_____ Ext. _____

Pharmacy:
Name:_____Address: _____
Phone (____) _____-_____ Fax (____) _____-_____

Primary Insurance _____ Policy Holder Name _____
Policy Holder Sex: F M Policy Holder DOB ____/____/____
Policy Holder SSN# _____ Policy Holder Relationship to Patient _____
ID # _____ **Group #** _____
Secondary Insurance _____ Policy Holder Name _____
Policy Holder Sex: F M Policy Holder DOB ____/____/____
Policy Holder SSN# _____ Policy Holder Relationship to Patient _____
ID # _____ **Group #** _____

PLEASE TELL US HOW DID YOU HEAR ABOUT US?

☐ Internet Search	☐ Friend/Family Member
☐ Outside Banner	☐ Magazine/News
☐ Other_____	☐

BILLING AND CORRESPONDENCE INFORMATION

PERSON TO WHOM ALL BILLING & CORRESPONDENCE SHOULD BE MAILED:

NAME: _____Relationship_____

Address _____City _____St____ Zip_____

Phone: Home_____Cell_____Work_____

IS THERE A POWER OF ATTORNEY? ☐ No ☐ Yes (please provide a copy for patient's file)

POA: Name_____

Address_____City_____St_____ Zip_____

Phone: Home_____Cell_____Work_____

The power of attorney will be contacted first for all matters unless otherwise directed.
If there is no power of attorney we will contact the patient named directly above for all matters.

In the event the patient, power of attorney or primary contact named above cannot be reached please provide the name of another person we may contact.

Name_____

Relationship to patient_____

Phone: Home_____ Cell_____ Work_____

PATIENT PORTAL:
I understand unless specified otherwise, all correspondence, including lab and x-ray results, will go through the patient portal. I have been given access and will access my records there.

_____ _____
Signature of Patient/Guardian Date

Request For and Consent to Medical Treatment

The undersigned hereby grants authorization for medical treatment and procedures that may be ordered, requested or deemed necessary for the patient named. The undersigned fully understands that the practice of medicine and surgery is not an exact science and herewith acknowledges that no guarantees have been made as to the results or outcomes of any treatments or procedures. In the even that an unfavorable response is indicated by the patient then said patient agrees to communicate their findings to this office for further evaluation and follow up or referral to a specialist if needed.

This office uses nutritional supplements as a means to improve the general health and well-being of the patient. The patient agrees and understands that use of supplements and dosages may differ from that which is listed on the label. Please not that this office receives the usual and customary profit from supplement sales from office purchases only. We do NOT receive any revenue from purchases made outside of Vine Medical. If there is any question about the use of a natural remedy or supplement then the patient agrees to communicate that with the treating provider. ***The provider has the right to refuse treatment or dismiss any patient that she feels she cannot help.***

FINANCIAL POLICY

Payment is FULL is expected at the time of service. This includes fees for labs, test kits or specialty services. If payment arrangements are needed or circumstances warrant special consideration then please contact our Office Manager ahead of time. ***Balances are not carried over for any period longer than 30 days unless prior arrangements have been made. After 90 days, all balances will be turned over to our collection agency.***

All returned checks or authorized bank/credit transactions that are dishonored will be subject to a $35 administrative fee.

By signing below, you are also agreeing

Patient Name (Print) _____

Parent Name (If under 18) _____

Patient Signature _____ Date: _____

Parent Signature (If under 18) _____ Date: _____

Vine
medical associates

Policies and Fees Disclosure

Appointments:

In order to provide the highest possible healthcare we ask that appointments be made in advance. You can call our office during normal business hours to schedule an appointment.

Office Appointments allow our doctors and staff to provide dedicated attention to our patients' needs. Therefore, we have a 24 hour cancellation policy.
A **$50 fee** will be charged for all missed transportation & office appointments or appointments not cancelled at least 24 hours in advance.

Administrative Hours:

Monday, Tuesday, Wednesday, Friday from 8:00 a.m. to 4:00 p.m. Thursdays 9:00 a.m. to 4 p.m.
Closed for lunch daily from 12:00 p.m. to 1:00 p.m.

Insurance:

We are sensitive to the rising cost of medical care and attempt to keep our fees as low as possible while providing quality care. Our office participates in numerous insurance plans. Please contact your current insurance plan to verify physician participation. **At the time of each visit, please bring you current insurance card.** You will be asked to pay your **co-payment**, deductibles, and non-covered charges the day of service. We accept cash, checks, Visa, MasterCard, or American Express. We accept all major insurance plans except Medicaid and Kaiser.

Invoices for services rendered that are not covered by the insurance policy, will be processed and mailed at the end of each month.

IF PAYMENT IS FIVE (5) OR MORE BUSINESS DAYS PAST DUE, I AGREE THAT THE OUTSTANDING BALANCE WILL BE CHARGED TO THE CREDIT CARD. ADDITIONAL LATE FEE MAY BE ASSESSED. **Initial_____**

Cardholder Name: _____Zip: | | | | | | |

Credit Card: __MC __AMEX __VISA | | | | | | | | | | | | | | | | **Expiration Date:** | | | | **Sec. Code:** | | | |

I HAVE READ, UNDERSTAND AND AGREE TO THE FEES & POLICIES ABOVE.

Patient Signature:_____Date:_____

Vine Medical Associates, PC
11660 Alpharetta Hwy, Ste 290, Roswell, GA 30076
Phone (404) 446-3600 Fax (404) 446-3609

Vine
medical associates

Assignment of Benefits/ Release of Medical Information

I hereby authorize and request that payment of benefits by my primary insurance company _____, and my secondary insurance (if any) _____ be made directly to Vine Medical Associates for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Vine Medical Associates to disclose any and all written information from the above named insurance company and/or its designated representatives, at the determination of Vine Medical Associates. Such disclosure shall be for reimbursement purposes for those services received.
I hereby release Vine Medical Associates, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above named insurance company(s) or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:
1. I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services.
2. I agree to participate and assist Vine Medical Associates or its designated representatives with any appeal process necessary to collect payments for services rendered.
3. I am aware and have been advised of the provisions of Federal and State Statues, rules and regulations and provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. Vine Medical Associates is acting in filing for insurance benefits assigned to _____(patient name) and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s).
6. A firm contracted by Vine Medical Associates for billing and collection purposes may do billing.
7. Vine Medical Associates is appointed by me to act as my representative and on my behalf in any preceding that may be necessary to seek payment from my insurance carrier. This includes receiving a copy of my insurance plan's documents.
8. Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
9. Vine Medical Associates shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____	_____
Patient signature	Witness signature
_____	_____
Patient name (printed)	Witness name (printed)
_____	_____
Date	Date

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medical associates

Pain Medication and Prescription Refill Policy

1. I agree to allow **48 hours** for prescription refills. I understand that it is ***my responsibility*** to call before I run out of pills.
2. I understand that a follow-up visit may be required from my physician in order to obtain a refill.
3. I agree to take all medications as instructed. I am not allowed to change the dosage or alter the time schedule without first talking to the medical staff.
4. No refills will be called in after hours or on week-ends, unless in an emergency.
5. Only one pharmacy may be used for filling prescriptions.
6. I must keep all appointments as recommended.
7. I will not give, trade or sell medications.
8. I will not combine any narcotic medication with alcohol.
9. I will not obtain additional prescriptions for controlled substances from other physicians or the Emergency Room.
10. Altering or forging a prescription will be grounds for immediate termination from this practice. This is a felony and WILL be reported.
11. Patients may be terminated from the practice after 30 days' notice for noncompliance in taking prescription medications.
12. Breech of any of the above will result in this office no longer prescribing controlled substances to you or you being terminated as a patient of this practice.
13. I understand that there is a ***$50 NO SHOW FEE*** if I do not cancel within 24 hours of my appointment.
14. I give permission for Vine Medical Associates to speak with my pharmacists regarding my prescriptions.

Are you changing to a new local pharmacy? You should call your new pharmacy and request that your prescriptions be transferred from your old pharmacy. **If you change pharmacies and do not tell us, then your medication will be sent to the last one we have on file for you and it will be up to you to have transferred.**
Are you changing to a new mail order pharmacy? Some pharmacies will transfer your prescriptions to the new pharmacy. If you still have refills on your current prescriptions, please check with current mail order pharmacy to see if your prescription refills can be transferred.
Are you going on an extended vacation and need to use an out-of-town pharmacy? You need to call the NEW pharmacy that you will be using and have them contact your hometown pharmacy to have your prescriptions transferred. When you return home, you may have to reverse the process.

I HAVE READ, UNDERSTAND AND AGREE TO THE POLICIES ABOVE. I UNDERSTAND THAT IF I *DO NOT SIGN* THIS DOCUMENT, MY PHYSICIAN MAY REFUSE TO PRESCRIBE CONTROLLED SUBSTANCES.

Patient Name _____ **(print)**

Signature _____ **Date** _____

11660 Alpharetta Hwy, Ste 290, Roswell, GA 30076
Phone (404) 446-3600 Fax (404) 446-3609

REFILL REQUIREMENTS

CONDITION	OFFICE VISIT FREQUENCY	LAB TEST FREQUENCY	NOTES
Diabetes	Every 3-4 months	Every 3-6 months or as indicated by the provider	
Hypertension	Every 4-6 months	Every 4-6 months or as indicated by the provider	
Hormone Support	Every 6 months	Every 6-12 months or as indicated by the provider	
Asthma	Every 4-6 months	Every 6-12 months or as indicated by the provider	
Controlled Substances	Every 3 months—NO EXCEPTIONS	2 Random drug tests per year or as indicated by the provider	
High Cholesterol	Every 4-6 months for established diagnosis—May be more frequent for a new diagnosis	Every 6-12 months or as indicated by the provider	
Thyroid Disorder	Every 3-6 months	Every 4-12 months or as indicated by the provider	

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Patient. Please Sign for Permission to Treat
If Patient is a Minor. Parents sign Here for Permission to Treat in your Absence

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, (a Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification Act, which requires healthcare organizations to comply with specific rules regarding:

> Unique Identifiers for health plans, providers, individuals, employers Healthcare Transaction & Code Sets for transmitting data electronically Privacy regulations over disclosure and use of health information Security regulations over protections of electronic health information.

It is our policy to NOT release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and /or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. ***If you would like to have information released to someone other than yourself, please complete the following.***

I authorize Vine Medical Associates to leave medical information pertaining to my care by the following methods and ***will assume responsibility to notify them whenever this information changes.***

Home Telephone	YES	NO	Voice Mail	YES	NO
Answering Machine	YES	NO	Cell Phone/Voicemail	YES	NO
Work Telephone	YES	NO	Email	YES	NO

May we fax medical records for referrals to specialists or hospitals?	YES	NO
May we contact your previous doctor?	YES	NO
May we contact your pharmacy to obtain your medication list?	YES	NO
May we obtain/share vaccination information with the GA Immunization Registry?	YES	NO

If no, Vine Medical Associates reserves the right to not prescribe medications to you.

Please list names of people with whom we can discuss your medical care:

Spouse Name _____ YES NO

Parent Name _____ YES NO

Other Name _____ YES NO

Relationship _____ Phone (___) _____-_____

_____ _____
Signature of Patient/Guardian Date

Patient Consent for Use of Email Communications

To better serve our patients, this office has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at **vinemedicalassoc@gmail.com. Please remember however, that this form of communication is not appropriate for use in an emergency.** The turnaround time for routine patient communications is 24-48 hours. The service provider may delay message delivery.

Should you require urgent or immediate attention, this medium is not appropriate.

When sending an email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name and return phone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of the email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to Dr. Turner, Vine Medical staff and/or colleagues would have access to this information.

We strongly encourage you to use our secure patient portal for sensitive medical information. Your lab results will remain to be posted to the portal.

I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to unforeseen circumstances. I understand and agree to the above email policy.

By signing below, you are agreeing that we may send you medical related correspondence to you via email and that we may respond to your emails to us via email.

_____	_____
Patient signature	Witness signature
_____	_____
Patient name (printed)	Witness name (printed)
_____	_____
Date	Date

ELECTRONIC COMMUNICATIONS AGREEMENT FOR PERSONAL HEALTH INFORMATION

Vine Medical Associates and ("Patient")_____ herein enter into this Electronic Communications Agreement for Personal Health Information ("PHI Agreement") regarding the use of email or other electronic communications/transmissions:

1. **Emails, text messages, videoconferencing, and all other electronic communications may be utilized between the Physician and the Patient that includes the Patient's Personal Health Information ("PHI")**.

2. **The Patient agrees to inform the Physician of any changes to the Patient's authorized email address. The Patient acknowledges that should the Patient exchange email with the Physician from another email address, the Patient authorizes the Physician to use that email address for communicating PHI as well.**

3. **For all other services, the Patient and the Physician may use telephone (landline or mobile), facsimile, mail, or in-person office visits.**
4. **Under no circumstances shall email or electronic communications be used by the Patient or the Physician in emergency situations. If the Patient is in an emergency situation, the Patient must call 9-1-1.**
5. **The Physician and his/her staff value and appreciate the Patient's privacy and take security measures such as encrypting the Patient's data, password-protected data files, and other authentication techniques to protect the Patient's privacy. The Physician shall comply with HIPAA/HITECH with respect to all communications subject to the terms of this PHI Agreement reflecting the Patient's explicit consent to certain communication amenities. The Patient acknowledges and understands that any email or text communication may become part of the Patient's medical record based on the discretion of the Physician.**
6. **The Patient acknowledges that electronic communication platforms and portable data storage devices are prone to technical failures and, on rare occasions, the Patient's information or data may be lost due to technical failures. The Patient nevertheless authorizes the Physician to communicate with the Patient, and each other, as set forth in this PHI Agreement. The Patient shall hold harmless the Physician, and its owners, officers, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of or caused by such technical failures that are not directly caused by the Physician. If the Patient uses non-encrypted email, or instructs the Physician to use non-encrypted email containing PHI, the Patient shall hold harmless the Physician, and their respective owners, directors, agents, and employees from and against any and all demands, claims, and damages to persons or property, losses and liabilities, including reasonable attorney's fees, arising out of any third-party interception of such non-encrypted email.**
7. **The Physician will obtain the Patient's express consent in the event that the Physician is required or requested to forward the Patient's identifiable information to any third party, other than as specified in the Physician's Notices of Privacy Practices, Physician-Patient Agreement or as mandated by applicable law. The Patient hereby consents to the communication of such information as is necessary to coordinate care and achieve scheduling with the Patient and all responsible parties. The Patient identifies the following individuals or entities as additionally authorized to receive the Patient's PHI from the Physician in connection with authorized consulting, education, and all other aspects of supporting the Patient's care: ___**

8. The Patient acknowledges that the Patient's failure to comply with the terms of this PHI Agreement may result in the Physician terminating the email and electronic communications relationship, and may lead to the termination of the Physician-Patient Agreement provided between the Physician and the Patient.

9. The Patient hereby consents to engaging in electronic and after-hours communications referenced above regarding the Patient's PHI. The Patient may also elect to designate immediate family members and/or other responsible parties to receive PHI communications and exchange PHI communications with such designated family members and/or other responsible parties.

10. The Patient acknowledges that all electronic communication platforms, while convenient and useful in expediting communication, are also prone to technical failures and on occasion may be the subject of unintended privacy breaches. Response times to electronic communication and authentication of communication sources involve inherent uncertainties. The Patient nevertheless authorize the Physician to communicate with the Patient, and each other, regarding PHI via electronic communication platforms referenced in this Agreement, and with those parties designated by the Patient as authorized to receive PHI. The Physician will otherwise endeavor to engage in reasonable privacy security efforts to achieve compliance with applicable laws regarding the confidentiality of the Patient's PHI and HIPAA/HITECH compliance. The Patient has received the Physician's Notice Of Privacy Practices and acknowledges receipt of same pursuant to the attached acknowledgement.

11. The Patient shall have the right to request from the Physician a copy of the Patient's PHI and an explanation or summary of the Patient's PHI. The following services performed by the Physician shall not be the subject of additional charges to the Patient: maintaining PHI storage systems, recouping capital or expenses for PHI data access, PHI storage and infrastructure, or retrieval of PHI electronic information. However, the Patient's Program Fee may include skilled technical staff time spent to create and copy PHI; compiling, extracting, scanning and burning PHI to media and distributing the media with media costs; the Physician's administrative staff time spent preparing additional explanations or summaries of PHI. If the Patient requests that the Patient's PHI be provided on a paper copy or portable media (such as compact disc (CD) or universal serial bus (USB) flash drive), the Physician's actual supply costs for such equipment may be charged to the Patient.

12. This Agreement will remain in effect until the Patient provides written notice to the Physician that the Patient revokes this Agreement or otherwise revokes consent to communicate electronically with the Physician. The Patient may revoke this Agreement at any time, and agrees to provide the Physician with a notice period of thirty (30) business days for any request to remove the Patient from any PHI electronic communications database or network. Revocation of this Agreement will not affect the Patient's ability to receive medical treatment, but will preclude the Physician from providing treatment information in an electronic format other than as authorized or mandated by applicable law. A photocopy or digital copy of the signed original of this Agreement may be used by the Patient or the Physician for all present and future purposes.

SIGNED BY:

PATIENT:
Signature:
_____

Printed Name: _____

PHYSICIAN:
Signature:
_____

Printed Name: _____
Title: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to the Patient:
The Physician is required to provide the Patient with copies of the Notice of Privacy Practices, which state how he/she may use and/or disclose the Patient's health information. Please sign this form to acknowledge receipt of the Notice.
The Patient may refuse to sign this acknowledgment, if he/she wishes.

The Patient acknowledges that he/she has received a copy of the Physician's Notices of Privacy Practices.

Patient's name (please print): _____
Signature: _____
Date: _____

FOR OFFICE USE ONLY

The Physician and/or assigned parties made every effort to obtain written acknowledgment of receipt of the Notice of Privacy Practices from the Patient but it could not be obtained because:

☐ The Patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgment.

☐ The Physician and/or assigned party was unable to communicate with the Patient.

☐ Other: _____

_____

_____

PATIENT NAME: _____ DATE: _____

HISTORY INTAKE

Personal History

Name _____Date of Birth__/__/____Age ___Date:_____

Birthplace_____

Your Doctor _____Referred by_____

Allergies

2 Problems you Would like to Addressed Today: (rank in terms of importance to you)

1. _____
2. _____

Other Problems you Would like Addressed at your Next Appointment:

1. _____
2. _____

PAST MEDICAL, SURGICAL & TRAUMA HISTORY

List prior illness, injury, hospitalization, surgery, and/or trauma:

Hospitalizations or Surgery and Date:

_____ _____

_____ _____

_____ _____

_____ _____

Lifestyle/ Self-Care Issues

Do you smoke cigarettes? ☐ YES ☐ NO If yes, how many? #____yrs. _____ packs per day

Did you ever smoke? ☐ YES ☐ NO If yes, when did you quit? _____

Do you drink alcohol? ☐ YES ☐ NO If yes, how much? Type _____&_____drinks per week

Do you drink caffeinated beverages? ☐ YES ☐ NO If yes, how many cups per day? _____

Do you use recreational drugs? ☐ YES ☐ NO If yes, which? _____

Do you manage stress well? ☐ YES ☐ NO ☐ NOT SURE ☐ NEED HELP

Do you exercise regularly? ☐ YES ☐ NO If no, why? _____

Do you enjoy your job? ☐ YES ☐ NO If no, why? _____

What is your religious preference? ☐ CHRISTIAN ☐ JEWISH ☐ MUSLIM ☐ HINDU ☐ OTHER

Do you have a pet? ☐ YES ☐ NO If yes, what kind?_____

Occupation_____

Yesterday's Diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

11660 Alpharetta Hwy, Ste 290, Roswell, GA 30076
Phone (404) 446-3600 Fax (404) 446-3609

Initials_____
Date_____

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/Brother	Spouse	Children
Aids							
Alcoholism							
Allergies/Asthma							
Anemia							
Arthritis							
Birth Defects							
Bleeding Disorder							
Cancer (type)							
COPD/ Emphysema							
Dementia							
Depression/Anxiety							
Diabetes							
Epilepsy/seizures							
Glaucoma							
Heart Attack(age)							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Migraine Headaches							
Stroke							
Tuberculosis							
Ulcers							
Living (Y/N)							

Social History (check those that apply):

Marital Status:
☐ single
☐ married
☐ divorced
☐ widowed

Education level completed:
☐ high school
☐ college
☐ professional school
☐ other:

Major Stressors in Last 6 Months:
☐ money ☐ home life
☐ job ☐ children
☐ marriage ☐ other: _____

Lives with you:
□ alone □ family □ roommate □ significant other
□ children (list sex/ages):_____

Travel Outside of US:

HEALTH SCREENING HISTORY

Devices

__Eyeglasses
__IUD, Diaphragm
__Brace (Neck/Back)
__Hearing Aid
__Walker
__Wheelchair
__Contact Lens
__Artificial Limbs
__Pacemaker
__Dentures
__ Cane
__ Depends

Initials_____

Date_____

List the date of your most recent test or exam.
Physical_____
Chest X-ray _____
Rectal Exam_____
Colonoscopy/Sigmoidoscopy_____
Test for Blood in stool_____

Female:
Mammogram_____
Pap Smear_____
Self-Breast Exam _____
Breast Exam by Doctor_____
Bone Density_____

Male:
Self-Exam Testicle_____
Testicle Exam by Professional_____
Prostate Exam_____

List the date of your most recent immunization:
Tetanus_____ Hepatitis_____
Pneumonia_____ Flu Shot_____

Initials_____
Date_____

MEDICATION LIST			
Name	**Strength/Dosage**	**Frequency**	**Prescribed By:**

PHARMACY NAME: _____
PHONE:_____
FAX:_____

Vine Medical Associates

Suzanne Ferree Turner, MD
www.vinemedical.com
11660 Alpharetta Hwy Ste 290, Roswell, Ga 30076
Telephone (404) 446-3600 Fax (404) 446-3609

Authorization for Release of Information

Name:_____ Date of Birth: _____
Address: _____ City, State, Zip: _____

☐ I authorize Dr. Suzanne Ferree Turner
To release informati

AND/OR

☐ I authorize Dr. Suzanne Ferree Turner
to obtain information from:

_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ Phone # (include area code)	_____ Phone # (include area code)
_____ Fax # (include area code)	_____ Fax # (include area code)

PURPOSE OF THIS REQUEST: (Please check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)
☐ Radiology Reports ☐ Progress Notes ☐ Laboratory Test Results ☐ Medication and Problem List
☐Other:_____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. My authorization will expire:
☐When the requested information has been sent/ received.
☐ 90 days from this date ☐ Other: _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:
☐ When I am no longer receiving services from Dr. Suzanne Ferree Turner.
☐ One year from this date ☐ Other: _____

I understand that:
• I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
•I may cancel this authorization at any time by submitting a written request to Dr. Suzanne Ferree Turner, except where a disclosure has already been made in reliance on my prior authorization.
• If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
• If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
• Release of HIV-related information requires additional information.
• If the medical record information is not sent to another provider, there may be a charge of the requested records.

Signature of Patient or Representative: _____ Date: _____
Relationship to Patient (If requester is not the patient): ☐ Parent ☐ Legal Guardian
☐Other: _____

Patient or Representative has been provided a copy of this authorization: _____
Staff member providing copy