MARYLAND SURGEONS

Date_____

Name _____ Social Security # _____

Address _____ Date of Birth _____

City _____ State _____ Zip _____ Sex _____ Marital Status _____

Home Phone # _____ Work Phone # _____ Cell# _____

Employer _____ Preferred language:_____Race: _____

Email address: _____

Pharmacy: _____City: _____Pharmacy Phone #:_____

Person to Notify in an Emergency _____

Relationship _____ Phone Number _____

Primary Care Physician _____ Referring Physician _____

Insurance Information:

Primary Insurance _____

Are you the policyholder? _____Yes ____No (*this information is NOT on the card*)
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Secondary Insurance _____

Are you the policyholder? _____Yes ____No
If not, policyholder's name? _____ Relationship to Patient _____
Policyholder Date of Birth _____ Policyholder Employer _____

Other Health Care Providers

GYN Name_____Phone _____Fax_____

Gastroenterologist _____Phone_____Fax_____

Oncologist _____Phone_____Fax_____

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Date_____

ASSIGNMENT AND RELEASE:
I hereby assign my insurance benefits to be paid directly to the physician.
I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
I authorize the physician to release any medical information required to process this claim.
I authorize my provider's office to contact me by telephone to remind me of my appointments.
I authorize Saint Agnes Health to download my current medications for purposes of insurance payment.
I have received a Notice of Privacy Practice, Notice of Patient Rights and Responsibilities
I hereby consent to treatment by my Saint Agnes Health provider(s). I authorize Saint Agnes Health to release to referring or subsequent healthcare provider, reports of my medical condition that will assist him or her in my continued care and as needed to process claims and for general healthcare operations, which may include use of an electronic health information exchange

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.
I understand that this consent will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this consent to the Practice. However, any disclosures that occured prior to the date of the revocation will not be affected.

By signing this consent, I authorize **St. Agnes HealthCare** and its affiliates to disclose my protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name:_____ Relationship:_____

Method of Communication:_____

Name:_____ Relationship:_____

Method of Communication:_____

May we contact you regarding your protected health information, health status, appointments, and test results?

_Yes, you may contact me by e-mail; my address is:_____

_No, do not contact me by email for this purpose.

_Yes, you may contact me by phone; my daytime phone numbers are:
( )_____-_____ ( )_____-_____

_Yes, you may contact me at the following fax number ( )_____-_____
May we leave a message regarding your protected health information at the numbers you provided above?
__Yes __No

Signed_____ **Date:**_____

Maryland Surgeons

Name_____ DOB_____ Today's date_____

Reason for visit:_____ PCP: _____
Allergies: ❒ NONE ❒ latex ❒ Medication

_____
Current medications (include dosage):
❒Blood thinners ❒Weight loss medication

_____
_____
_____

Medical problems (check all that apply)

- ☐ Asthma
- ☐ Blood clot (DVT/pulmonary embolism)
- ☐ Cancer _____
- ☐ Chronic lung disease
- ☐ Cirrhosis
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Heart attack
- ☐ Heart failure
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Kidney disease
- ☐ Prostate enlargement
- ☐ Sleep apnea
- ☐ **See a cardiologist**
- ☐ Other:

_____
_____

Past surgeries: ❒none ❒gallbladder ❒hernia repair ❒colon resection ❒hysterectomy ❒cardiac stent ❒pacemaker ❒heart surgery ❒lung surgery ❒prostate ❒other:

_____
_____

Problem with anesthesia? ❒No ❒Yes _____

Family history ❒ cancer ❒heart trouble ❒other _____ which person? _____

Smoking: ❒ tobacco ❒marijuana ❒vaping ❒never smoked
❒smoker: how much_____ ❒ex-smoker: quit when_____
Alcohol use: ❒none ❒rarely ❒often ❒daily
Occupation: _____

REVIEW OF SYSTEMS: check any you are currently experiencing

General:	❒NONE	❒weight gain_____, ❒weight loss _____, On purpose? ❒yes ❒no
Eyes/Skin	❒NONE	❒ yellow eyes, ❒ yellow skin
Respiratory	❒NONE	❒shortness of breath, ❒cough
Cardiac	❒NONE	❒chest pain, ❒irregular heartbeat
Gastrointestinal	❒NONE	❒blood in stool, ❒diarrhea, ❒constipation
Genitourinary	❒NONE	❒difficulty urinating, ❒kidney stones
Musculoskeletal:	❒NONE	❒pain where? _____
Psychiatric	❒NONE	❒depression, ❒anxiety

Authorization for the Use and Disclosure of Protected Health Information (PHI)

Patient Name: _____ Phone: _____

Email Address: _____ Date of birth: _____

Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as described on this form.

Select the location(s) to release information

☐ Ascension Saint Agnes Hospital

☐ Other (name and address): _____

☐ Ascension Medical Group/Ascension Employed Clinician Network

Provider Name: _____

Provider Address: _____

Note: forward to the appropriate location for processing as needed.

I understand that:

1. Information relating to **ALCOHOL/SUBSTANCE USE TREATMENT, MENTAL HEALTH TREATMENT, GENETIC TESTING**, and/or **COMMUNICABLE DISEASES** will not be shared unless I specifically give permission. By placing my initials below, I specifically authorize the release of such information to the person(s) indicated on this form.

Initial	Health Information Description
	Alcohol and/or Substance Use Disorder Treatment Information (records from alcohol/drug treatment programs)
	Mental Health Treatment Information (except psychotherapy notes, which may require additional authorization)
	Genetic Testing Information
	Communicable Diseases (including but not limited to HIV/AIDS-Related Information, venereal disease, and tuberculosis, as defined by federal and state law)

2. I can revoke this authorization by writing to: Ascension St. Agnes HIM Department, 900 Canton Ave, Baltimore, MD 21229. This revocation will be effective except to the extent Ascension has already relied upon this authorization.
3. I have the right to inspect and receive a copy of the information disclosed pursuant to this authorization.
4. Signing this authorization is voluntary. Ascension may not condition treatment, payment, enrollment in health plans, or eligibility for benefits on my signing or refusal to sign this authorization, except in limited circumstances.
5. Except in limited circumstances, my information may be re-disclosed (shared) by the recipient and no longer protected by federal or state law. I understand that substance use disorder information is protected by the Federal Confidentiality of Substance Use Disorder Patient Records Law (42 CFR Part 2) and may not be re-disclosed without the written consent of the person to whom it pertains unless permitted by 42 CFR Part 2.
6. This information has been disclosed in accordance with Title 4, Subtitle 3 of the Annotated Code of Maryland. Any individual or agency receiving protected health information pursuant to this Authorization is prohibited from

making further disclosure of this information except as specifically permitted under Md. Code, Health-Gen. § 4-302(d).

7. Authorization will end one year (365 days) from the date signed (or 180 days for mental health and alcohol/substance use disorder information), unless stated here (specific event or date): _____

Purpose for release of information

☐ At my request ☐ Continuity of Care

☐ Other (please explain, including if for a government benefit or program):_____

Person receiving this information

☐ Self ☐ Other: _____

Form/Format (fees may apply; a fee approval will be provided prior to release)

We will provide the information in all reasonable formats; if we can't provide the requested information in the requested format, we will contact you to agree on an alternative.

☐ Mail paper to: _____

☐ Pick up, paper ☐ Electronic Portal (list name): _____

☐ Fax (number): _____ ☐ CD/DVD ☐ USB

☐ Secure Email: _____

☐ Other: _____

Description of the information to be released

☐ Entire medical record from the facility/location indicated

☐ Records related to the following dates: _____

☐ Radiology films/images (list type of test and date):_____

☐ Abstract (summary) of information related to the following dates: _____

☐ Records sent to the provider/entity indicated above by a non-Ascension provider and kept by Ascension for use in my care (i.e., third party records), explain: _____

☐ Other - please specify (e.g., lab reports, billing records; consent forms):_____

My questions, if any, have been answered. In addition, I have been provided or offered a copy of this form if Ascension has asked me to complete this form.

Patient Name (Printed): _____

Signature: _____ Date: _____

If the person signing is not the patient, please print the name and type of authority to sign. Supporting documentation should be provided at the time of the request (e.g., guardian of minor, power of attorney; death certificate).

_____

Ascension Use Only: Medical Record Number: _____Date Received: _____