OLYMPUS FAMILY MEDICINE

New Patient Registration Form

PATIENT INFORMATION

LEGAL NAME: _____
Last First MI

DATE OF BIRTH: _____/_____/_____ GENDER: Male Female SOC SEC #: _____-_____-_____
MM DD YYYY

CURRENT ADDRESS:

_____
Street Address Apartment Number

_____
City State Zip

Please Indicate Your Preferred Contact Method Below:

- Cell Ph: _____
- Home Ph: _____
- Work Ph: _____
- Email: _____

PARTNER NAME: _____ Marital Status: S M D W
Last First

EMERGENCY CONTACT: _____ Phone # _____
Last First MI

PREFERRED PHARMACY (Name & Address): _____

HOW DID YOU HEAR ABOUT US (circle)? Insurance Friend Family Member Internet Facebook Other

INSURANCE INFORMATION

Primary Insurance Plan

INSURANCE PLAN NAME: _____ Phone # _____

INSURANCE CARD: Member ID # _____ Group # _____
(Policy Number)

INS. PLAN ADDRESS: _____ Listed PCP: YES NO
Street Address

_____ _____
City State Zip (If YES, please indicate PCP name)

PRIMARY INSURED'S NAME: _____
Last First MI

PRIMARY'S DOB: ____/____/_____ PATIENT'S RELATIONSHIP TO PRIMARY: Self Child Spouse Other: _____
MM DD YYYY

Secondary Insurance Plan (If Applicable)

INSURANCE PLAN NAME: _____ Phone # _____

INSURANCE CARD: Member ID # _____ Group # _____
(Policy Number)

INS. PLAN ADDRESS: _____ Listed PCP: YES NO
Street Address

_____ _____
City State Zip (If **YES**, please indicate PCP name)

PRIMARY INSURED'S NAME: _____
Last First MI

PRIMARY'S DOB: ____/____/_____ PATIENT'S RELATIONSHIP TO PRIMARY: Self Child Spouse Other: _____

PRESENT HEALTH SYMPTOMS

Please review and mark **ALL** items that have applied to you **within the last month** (including today):

OVERALL:	☐ NONE	☐ WEIGHT LOSS	☐ WEIGHT GAIN	☐ FATIGUE	☐ LOSS OF APPETITE
EYES:	☐ NONE	☐ EYE PAIN	☐ DOUBLE VISION	☐ SEVERE REDNESS	☐ CRUSTING
EARS:	☐ NONE	☐ EAR PAIN	☐ HEARING LOSS	☐ RINGING IN EARS	☐ DIZZINESS
NOSE:	☐ NONE	☐ RUNNY NOSE	☐ NASAL CONGESTION	☐ NOSEBLEEDS	☐ SINUS PAIN/PRESSURE
MOUTH/THROAT:	☐ NONE	☐ SORE THROAT	☐ SORES IN MOUTH	☐ TOOTH PAIN	☐ HOARSENESS
		☐ PROBLEMS SWALLOWING		☐ JAW PAIN	
CHEST/HEART:	☐ NONE	☐ CHEST PAIN	☐ RACING/POUNDING HEART	☐ LEG PAIN / LIMP W/ WALKING	
		☐ PROBLEMS BREATHING WITH LYING DOWN		☐ ARRHYTHMIA	
RESPIRATORY:	☐ NONE	☐ DRY COUGH	☐ WHEEZING	☐ SHORTNESS OF BREATH	
		☐ WET COUGH	☐ COUGHING UP BLOOD OR MUCUS WITH BLOOD		
STOMACH:	☐ NONE	☐ HEARTBURN	☐ NAUSEA/VOMITING	☐ ABDOMINAL PAIN	☐ VOMITING UP BLOOD
BOWELS:	☐ NONE	☐ DIARRHEA	☐ CONSTIPATION	☐ BLACK/BLOODY STOOLS	
		☐ UNUSUAL CHANGE IN STOOL SIZE/SHAPE/COLOR			
URINARY TRACT:	☐ NONE	☐ BLOOD IN URINE	☐ INCREASED URINATION	☐ DIFFICULTY URINATING	
		☐ PAIN / DISCOMFORT WITH URINATION		☐ WAKING TO URINATE _____ TIMES PER NIGHT	
REPRODUCTIVE:					
FEMALES:	☐ NONE	☐ MENSTRUAL PAIN	☐ BREAST PAIN	☐ VAGINAL DISCHARGE	☐ PAIN W/ INTERCOURSE
		☐ PREGNANT	☐ BREASTFEEDING	☐ FIRST DAY OF LAST MENSTRUAL PERIOD: _____	
MALES:	☐ NONE	☐ TESTICULAR PAIN	☐ PENILE DISCHARGE	☐ LUMP/ SWELLING IN SCROTUM/ TESTICLE(S)	
MUSC/SKEL:	☐ NONE	☐ BACK PAIN	☐ MUSCLE/JOINT PAIN	☐ LIMITED RANGE OF MOTION IN JOINTS	
SKIN:	☐ NONE	☐ RASH	☐ REDNESS	☐ CHANGING MOLES/WARTS OR OTHER LESIONS	
		☐ SORES			
NEUROLOGICAL:	☐ NONE	☐ SEIZURES	☐ PROBLEMS WITH COORDINATION		
		☐ MEMORY/SENSORY PROBLEMS		☐ WEAKNESS / NUMBNESS / TINGLING	
ENDOCRINE:	☐ NONE	☐ UNUSUAL CHANGES WITH SKIN OR HAIR		☐ INCREASED SENSITIVITY TO TEMPERATURE CHANGES	
BLOOD:	☐ NONE	☐ BLEEDING GUMS	☐ FREQUENT NOSEBLEED	☐ SWOLLEN GLANDS	
		☐ SWOLLEN HANDS OR FEET		☐ UNUSUAL BRUISING	
IMMUNE:	☐ NONE	☐ SNEEZING	☐ ITCHY EYES	☐ FREQUENT SINUS, EAR OR RESPIRATORY INFECTIONS	
MENTAL HEALTH:	☐ NONE	☐ MOOD SWINGS	☐ EMOTIONAL CHANGES	☐ THOUGHTS OF HURTING SELF OR OTHERS	
		☐ ANXIETY/DEPRESSION		☐ PROBLEMS WITH MAINTAINING ATTENTION	

PAST MEDICAL HISTORY

Please indicate any of the following medical conditions you **have now** or have **ever had** in the past:

☐ ASTHMA	☐ EMPHYSEMA	☐ CHRONIC BRONCHITIS	☐ SEASONAL ALLERGIES
☐ SINUS INFECTIONS	☐ ARTHRITIS	☐ OSTEOPOROSIS	☐ GOUT
☐ HIGH CHOLESTEROL	☐ HIGH BLOOD PRESSURE	☐ HEART ATTACK	☐ STROKE
☐ GLAUCOMA	☐ ANEMIA	☐ CHRONIC HEARTBURN	☐ GALL BLADDER DISEASE
☐ BLEEDING DISORDER	☐ ULCERS	☐ THYROID DISORDER	☐ DIABETES
☐ KIDNEY DISEASE	☐ TUBERCULOSIS	☐ HEPATITIS (type) _____	☐ DEPRESSION/ANXIETY
☐ MENTAL ILLNESS	☐ EPILEPSY/SEIZURES	☐ MIGRAINES	☐ ADHD
☐ CANCER (type): _____		☐ OTHER _____	

STD/HIV HISTORY & RISK FACTORS:

☐ NONE	☐ UNPROTECTED SEX	☐ IV DRUG USE
☐ OCCUPATIONAL EXPOSURE	☐ HIV / AIDS	☐ TRANSFUSION (Before 1980)
☐ HEPATITIS (type) _____	☐ CLOSE CONTACT WITH STD / HIV POSITIVE PERSON	
☐ HISTORY OF PREVIOUS STD (type) _____		

PREVIOUS SURGERIES AND/OR HOSPITALIZATIONS

SURGERY OR ILLNESS	HOSPITAL	YEAR

SOCIAL HISTORY

Please complete the following sections. This information is important for guiding medical decisions related to your care.

OCCUPATION / EMPLOYER: _____ RECENT CHANGE? YES ☐ NO ☐

EDUCATION: ☐ High School ☐ Some College ☐ Degree RELIGIOUS PREF: _____

EXERCISE HABITS: ☐ Rarely ☐ 1-3 times/ week ☐ >3 times/ week # OF CAFFEINATED BEVERAGES PER DAY: _____

PLEASE INDICATE YOUR ETHNIC ORIGIN:

☐ WHITE ☐ BLACK / AFRICAN AMERICAN ☐ AMERICAN INDIAN / ALASKA NATIVE

☐ ASIAN (Please Specify) ☐ HISPANIC / LATINO ☐ NATIVE HAWAIIAN / PACIFIC ISLANDER

☐ CHINESE ☐ VIETNAMESE ☐ INDIAN ☐ PERSIAN

☐ JAPANESE ☐ TAIWANESE ☐ PAKISTANI ☐ INDEONESIAN

☐ KOREAN ☐ CANTONESE ☐ ARMENIAN ☐ OTHER ASIAN

☐ 2 OR MORE ETHNIC ORIGINS: (Not Hispanic / Latino)

TOBACCO, ALCOHOL & DRUG HISTORY

RECREATIONAL DRUG USE? ☐ YES ☐ NO

CURRENT TOBACCO USE? ☐ YES ☐ NO

PAST TOBACCO USE? ☐ YES ☐ NO

TYPE OF TOBACCO? ☐ SMOKE ☐ DIP ☐ CHEW

AMOUNT DAILY (quantity): CIGARETTES: _____ PACK(S): _____ CAN(S): _____

YEARS OF USE: CIGARETTES: _____ PACK(S): _____ CAN(S): _____

HAVE YOU QUIT? ☐ YES, DATE (month/year): _____ ☐ NO

WOULD YOU LIKE TO QUIT? ☐ YES ☐ NO

ALCOHOL USE? ☐ YES ☐ NO

IF YES, NUMBER OF DRINKS IN AN AVERAGE: DAY: _____ WEEK: _____ MONTH: _____

ALLERGIES

Are you **allergic** to any medications or other substances? **Y** ☐ **N** ☐ If yes, please list item and reaction(s) below:

Medication Allergies	Reactions
Other Allergies	**Reactions**

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Reason Prescribed

FAMILY MEDICAL HISTORY

Please complete the following table regarding the medical history of your family members:

	FATHER	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER	☐ BRO ☐ SIS	☐ BRO ☐ SIS	☐ BRO ☐ SIS
Deceased?	☐	☐	☐	☐	☐	☐	☐	☐	☐
- If deceased, please list cause of death									
AGE (present or at time of death)									
HEALTH HISTORY									
ASTHMA	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐	☐	☐
HEART ATTACK/ HEART DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐	☐	☐
OBESITY	☐	☐	☐	☐	☐	☐	☐	☐	☐
GALLBLADDER DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐	☐	☐	☐
THYROID DISORDER	☐	☐	☐	☐	☐	☐	☐	☐	☐
EPILEPSY/ SEIZURES	☐	☐	☐	☐	☐	☐	☐	☐	☐
ANEMIA/ BLEEDING DISORDER	☐	☐	☐	☐	☐	☐	☐	☐	☐
DEPRESSION / ANXIETY	☐	☐	☐	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐	☐	☐	☐
TUBERCULOSIS	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALCOHOLISM	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD/ ADD	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALLERGIES: (Please list below)	☐	☐	☐	☐	☐	☐	☐	☐	☐
CANCER (Type)_____ _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALLERGIES: (Please list below) _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
HEREDITARY DISEASES: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐

Additional Information: _____

_____

_____

OLYMPUS FAMILY MEDICINE

CONSENT FOR TREATMENT

I, _____, hereby authorize employees and agents, including Physicians, Physician Assistants, and Nurse Practitioners, of *Olympus Family Medicine* to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice. If the doctor is unable to see me due to appointment availability, I may be offered an appointment with the physician assistant or nurse practitioner.

This facility has on staff a Physician Assistant and/or Nurse Practitioner to assist in the delivery of medical care. Physician Assistants and Nurse Practitioners are not doctors. These providers are graduates of a certified training program and are licensed by the state board. Under the supervision of a Physician, a Physician Assistant may diagnose, treat, and monitor common acute and chronic diseases, as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising Physician, but rather overseeing the activities of and accepting responsibility for the medical services provided. A mid-level provider may render such medical services that are within his/her education, training and experience, as approved by the Physician's discretion.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by **not** signing this consent, *Olympus Family Medicine* will **not** be able to provide medical care, except in case of emergency.

If Patient is a Minor:

I, _____, give my consent and authorization for *Olympus Family Medicine*,
(Parent's Full Name)
including physicians, physician assistants, nurse practitioners and medical assistants, to provide medical evaluation and treatment to my child, _____, when I am not available.
(Minor's Full Name)

I understand such treatment may include invasive and minor surgical procedures and that the staff of *Olympus Family Medicine* will make reasonable attempts to contact me prior to initiating treatment if consent is needed.

The duration of this consent is indefinite and continues until revoked in writing or until the child reaches the age of eighteen. I understand that by **not** signing this consent, *Olympus Family Medicine* will not be able to provide medical care, except in case of emergency.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name of Patient

4461 Coit Road, Suite 307 · Frisco, TX 75035 · Ph. 972-377-0322 · Fax 972-502-5515

OLYMPUS FAMILY MEDICINE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by the staff of *Olympus Family Medicine* in providing and arranging your medical care.

Olympus Family Medicine is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, heath care operations and as otherwise allowed by the law.

HIPAA PRIVACY ACT INFORMATION RELEASE FORM

May *Olympus Family Medicine* release medical information to anyone other than yourself?

___ **YES**, please release information to the following: ___ **NO**, only release information to me.

Name: _____ **Relationship**: _____

Contact Phone #: _____ **Email**: _____

Name: _____ **Relationship**: _____

Contact Phone #: _____ **Email**: _____

Check which of the following methods we may leave detailed information pertaining to your health:

____ Phone # _____

____ Voice Mail # _____

____ Email (Non-Encrypted) _____

By signing this form, you acknowledge that you have received a copy of *Olympus Family Medicine's* Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name of Patient

OLYMPUS FAMILY MEDICINE

PAYMENT AND PATIENT POLICIES

Below you will find our patient policies. These are non-negotiable and are not to be altered. Failure to initial agreement with ALL of the following policies will result in your inability to receive care from Olympus Family Medicine. Thank you for your understanding in this matter.

Please Initial All Below

x_____ **Co-Payments, Co-Insurance and Deductibles:** **ALL** Co-Payments, Co-Insurance, & Deductibles **MUST** be paid at time of service. The amount paid when services are rendered is an estimated amount based on the information we receive from your insurance company. Final determination of charges will be made after your insurance has been filed. We will send you a statement for any remaining balance. For your convenience, we accept MasterCard, Visa, Discover, and American Express. **Procedures-** Most insurance companies require patients to pay a **separate** Surgical Deductible for procedures such as cryo-surgery, biopsies, device insertion, and other surgical procedures. Check with your insurance BEFORE the procedure is performed. You are responsible for payment of the deductible at the time of service.

x_____ **Insurance:** All patients must provide a valid Driver's License and an **active** insurance card at the time of service. If you fail to provide us with correct insurance information, you will be required to pay the full amount of the service. It is YOUR responsibility to know your benefits. Please notify the receptionist of any insurance changes when arriving for your appointment. We file your insurance as a courtesy to you. **ALL payments are due at the time of service** including Copays, Co-Insurance, and Deductibles.

x_____ ***YOU are responsible for knowing your insurance policy and benefits.*** Your health insurance policy is a contract between you and your insurance company. As a courtesy, we file your claim with your insurer if you agree to have payments made directly to *Olympus Family Medicine*. If your insurance company does not provide payment within **90** days of the filing date, **YOU** will be required to pay the full amount of all services rendered or denied. If we later receive a check from your insurer, we will issue you a refund in the form of an account credit or check.

x_____ ***YOU are responsible for payment of all charges for services NOT covered by your insurance company.*** We do our best to determine your insurance benefits and coverage; however, due to the constant changes in insurance coverage, we cannot guarantee that Medicare or other insurance companies/policies will cover the services rendered. Your insurance company will make the final determination upon receipt of the claim. Medicare patients might have an additional ABN form to sign for potential non-covered services and in-house or laboratory testing.

x_____ **Billing:** Our billing is out-sourced to *Physicians Group Management (PGM).* Any balances owed to *Olympus Family Medicine* are due upon receipt of the billing statement via mailed check, online payment, or in-office payment. Please call *Physicians Group Management (PGM)* at: **1-888-336-8283** for all office billing inquiries. All billing questions concerning laboratory or radiology must be directed to the facility where services were performed (*LabCorp, Quest, etc.*).

x_____ **Delinquent Accounts:** If your account becomes delinquent **after 90 days**, and a payment is not made in an attempt to resolve the balance, your account will be turned over to a collection agency due to delinquency and you will be required to pay **all balances in full before any further services are rendered by our office**.

x_____ **Appointments***:* Please plan to arrive 10-15 minutes before your appointment time to update any changes in contact information or insurance. We require a **24-hour** notice to cancel or reschedule an appointment. Failure to do so, including late cancellations and missed appointments, will result in a **$50 charge**. No-shows will not be tolerated. Patients who repeatedly miss their appointments may have their care terminated with *Olympus Family Medicine*.

x_____ **Laboratory Results and Radiology Results**: In general, all labs and radiology results will be discussed at routine follow-up appointments and **WILL NOT BE HANDLED OVER THE PHONE**. Routine results are typically available for the provider to review in 7 business days. Some specialty labs can take up to 10 business days. Your provider will determine if you need an appointment or if the results are urgent and can be discussed over the phone. Results for sexually transmitted disease labs require an appointment. All billing questions concerning laboratory or radiology must be directed to the facility where services were ordered. **LabCorp:** 1-800-788-9892 ; **Quest Diagnostics:** 1-866-697-8378 ; **BioReference Laboratories:** 1-800-229-5227.

x_____ **Call Back Requests***:* The doctor will **NOT** take calls for non-urgent conditions during regular business hours. Returned calls and messages are typically conducted at the end of the business day; however, in most cases, the provider will call you within **24-hours.** Please leave a detailed message along with your Name, Date of Birth, and Phone Number.

x_____ **Medication Refills***:* We require **24-hours notice for routine medication refill requests**. Please do NOT have the pharmacy fax a refill request to our office. If you need a refill of a medication, it is the patient responsibility to alert the office, not the pharmacy. Please do NOT let your medications run out before calling us to request a refill. NO medications will be refilled on weekends. You MUST make an appointment for any refills of antibiotics, controlled substance medications, and narcotics. **Narcotics will NOT be prescribed without an appointment.**

x_____ **Pharmacy***:* If your insurance company requires you to use a specific pharmacy in order to receive prescription medicine benefits, please notify us. If your insurance company requires prescriptions to be sent from the doctor's office to the mail-order pharmacy, please fill out ALL appropriate forms with the required information and we will fax them to the number you provide. If you need to update a pharmacy, please be sure to let our office staff know.

x_____ **Forms***:* All requests to fill out forms such as FMLA, Disability Determination, Leave of Absence, Jury Duty Exemptions, and others require an office visit. The provider reserves the right to deny signing any requested forms.

x_____ **Referrals***:* If you need a referral, we will submit the referral paperwork to a specialist. If the specialist has NOT contacted you within **5 days**, please call us. Before booking an appointment with a specialist, YOU are responsible for checking that the specialist or facility is in-network on your insurance plan. We may send referrals to the physician or facility of your choice. **All HMO's** require a referral BEFORE seeing a specialist and require 72 hours to process.

x_____ **Medical Records***:* Medical Records will be released after a signed release is received from the patient. Patients requesting copies of medical records will be charged a base fee of $25.00. ALL Medical Record Requests will be addressed within **10 business days** of receipt of both the patient release form and appropriate payment.

x_____ **Inclement Weather**: In the case of inclement weather, we follow the Frisco ISD policy for closures and delayed openings. We will call you to reschedule your appointment on the first business day that we re-open.

x_____ **Annual Physicals**: Please allow 8-12 weeks to schedule an Annual Physical. **Two weeks prior** to your appointment, please come in for fasting lab work. The focus of an Annual Physical Exam is preventive care. The provider will review your lab work, perform a physical assessment, answer questions, update your treatment plan, and refill any maintenance medications for chronic conditions. Acute issues will **NOT** be addressed at an Annual Physical appointment. Well Woman Exams will **NOT** be covered in the Annual Physical appointment. You must schedule a follow-up appointment to discuss those conditions. It is the patient's responsibility to know and understand their insurance coverage. If any services recommended by your provider are not covered under your insurance plan, you must decline the service before it is performed in office. Otherwise, the cost of the denied service will be your responsibility.

Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my insurance claim. This authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this form I am responsible for payment of services in full before services are rendered. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our above policies.

By signing this form, you acknowledge that you have read and understand all of *Olympus Family Medicine's* Patient and Payment Policies listed above. You also attest that all of the information provided previously on this form is accurate and reliable to the best of your knowledge.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

_____

Print Name of Patient, Parent or Legal Guardian

AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize the following office or entity to disclose my individually identifiable health information as described below:

Doctor/Hospital Name: _____

_____ Street Address _____ Suite Number

Phone # _____

Fax # _____

_____ City _____ State _____ Zip

This information may include, but is not limited to, material concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

_____ Print Patient Name _____ Date of Birth _____ Social Security Number

Purpose of Information Release: Continuity of care for Primary Care Physician Office

Description of Information to be Released: (Check all that apply)

____ All Available Medical Records (Including, but not limited to all below listed options.)

Please only release the following specified information:

____ Hospital Admission Records / Operative Reports / Billing Records / Discharge Records

____ Radiology Reports & Films ____ Consultation Reports ____ Laboratory / Pathology Reports

____ Emergency Room Records ____ Physician's Orders ____ Physician's Notes & Progress Notes

____ History & Physical ____ Nurse's Notes ____ Specific Dates: _____

The health information described herein shall be released to:

Olympus Family Medicine
4461 Coit Road, Suite 307
Frisco, Texas 75035
Phone: 972-377-0322 **Fax**: 972-502-9515

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying this office in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ Signature of Patient or Patient's Representative _____ Date

_____ Printed Name of Patient's Representative

_____ Relationship to Patient *OR* _____ Legal Authority (attach supporting documentation)