MEDICAL INFORMATION & HIPAA RELEASE FORM

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PATIENT NAME_____DOB_____

I AUTHORIZE MICHAEL C. SPECK, M.D., P.A. TO DISCUSS AND/OR RELEASE MY PROTECTED HEALTH INFORMATION, INCLUDING LABS, TEST RESULTS, DIAGNOSIS AND TREATMENTS DISCUSSED TO THE FOLLOWING PERSONS:

NAME_____RELATION TO PT_____PHONE_____

NAME_____RELATION TO PT_____PHONE_____

☐ DO NOT RELEASE MY INFORMATION TO ANYONE

EMERGENCY CONTACT_____PHONE_____

I acknowledge that Michael C. Speck, M.D., P.A. has made available to me a copy of the Notice of Privacy Practices (HIPAA). This notice describes how this office may use and disclose my protected health information. I understand that I can obtain a complete copy upon my request. A copy is also available at gillespiecountyurology.com Your health information has been made available to other health clinics through our EHR Prisma account. To stop this sharing, please put in writing your preference to stop sharing your information. This release of information will remain in effect until terminated by the patient in writing.

QUESTIONS MEDICARE REQUIRES US TO ASK:

ADVANCE DIRECTIVE (PERSON WHO CAN MAKE HEALTH DECISIONS FOR YOU IF YOU ARE UNABLE)

☐ I HAVE AN ADVANCE DIRECTIVE ☐ I DO NOT HAVE AN ADVANCE DIRECTIVE ☐ DECLINE TO DISCUSS

DECISION MAKER_____

History of Tobacco Use:

☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Frequency/Amount: _____

History of Alcohol Use:

☐ Daily ☐ Occasional ☐ Former ☐ Never

Frequency/Amount: _____

PLEASE KEEP OUR OFFICE UPDATED ON YOUR CURRENT MEDICATIONS

DO YOU HAVE PROBLEMS WITH URINARY INCONTINENCE? ☐ YES ☐ NO

IF YOU ANSWERED YES, THEN WHAT FORM OF TREATMENT, OR CARE PLAN ARE YOU CURRENTLY USING? (EX. MEDICATIONS, LIFESTYLE CHANGES, SURGICAL) _____

PATIENT SIGNATURE_____DATE_____