

**MADSEN FAMILY MEDICINE**

**9631 N NEVADA STE 205**

**SPOKANE, WA 99218**

**PHONE: 509-688-6735 FAX: 509-232-0357**

*Acknowledgement of Receipt of Notice of Privacy Practices*

*I, \_\_\_\_\_, have received Notice of Privacy Practices from Madsen Family Medicine.*

*X \_\_\_\_\_ Date \_\_\_\_\_*

*In lieu of patient signature, I, \_\_\_\_\_, a staff member of Madsen Family Medicine, state that \_\_\_\_\_ has been given our current Notice of Privacy Practice.*

*X \_\_\_\_\_ Date \_\_\_\_\_*

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**MADSEN FAMILY MEDICINE**

**9631 N. NEVADA STE. 205**

**SPOKANE, WA 99218**

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**PLEASE PRINT**

**Patient Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Home Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home Phone** \_\_\_\_\_ **Cell** \_\_\_\_\_

**I authorize Madsen Family Medicine to leave lab, x-ray results, and appointment information on my home answering system.**

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**I authorize Madsen Family Medicine to release any and all medical information on myself to the below named individuals. This release also applies to any confidential information that might be contained in my medical record.**

**Individuals who my medical information may be released to:**

**Name** \_\_\_\_\_

**Date to and from** \_\_\_\_\_ / \_\_\_\_\_

**Name** \_\_\_\_\_

**Date to and from** \_\_\_\_\_ / \_\_\_\_\_

**Name** \_\_\_\_\_

**Date to and from** \_\_\_\_\_ / \_\_\_\_\_

**Name** \_\_\_\_\_

**Date to and from** \_\_\_\_\_ / \_\_\_\_\_

**PATIENTS SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

***If a patient has reached his/her fourteenth birthday ONLY the patient may authorize disclosure relating to sexual diseases, birth control, sexual activity, or drug usage.***

***Health History Questionnaire***

***Patient Name*** \_\_\_\_\_ ***Date of Birth*** \_\_\_\_\_

***Current Medications & Dosage:*** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***Drug Allergies:*** \_\_\_\_\_  
 \_\_\_\_\_

***Women Only:***

***Men Only:***

<i>Are you Pregnant</i>	<i>Yes</i>	<i>No</i>	<i>Penis Discharge</i>	<i>Yes</i>	<i>No</i>
<i>Planning pregnancy</i>	<i>Yes</i>	<i>No</i>	<i>Sores on Penis</i>	<i>Yes</i>	<i>No</i>
<i>Breast Lumps</i>	<i>Yes</i>	<i>No</i>	<i>Lumps on Testicles</i>	<i>Yes</i>	<i>No</i>
<i>Vaginal Discharge</i>	<i>Yes</i>	<i>No</i>	<i>Difficulty Urinating</i>	<i>Yes</i>	<i>No</i>
<i>Changes in Period</i>	<i>Yes</i>	<i>No</i>	<i>Frequent Urinations</i>	<i>Yes</i>	<i>No</i>
<i>Bladder Problems</i>	<i>Yes</i>	<i>No</i>			

***HABITS***

<i>Do you Smoke</i>	<i>Yes</i>	<i>No</i>	<i>IF YES how long?</i> _____	<i>How much?</i> _____
<i>Do you drink Alcohol</i>	<i>Yes</i>	<i>No</i>	<i>IF YES how often?</i> _____	<i>How much?</i> _____
<i>Caffeinated Bev.</i>	<i>Yes</i>	<i>No</i>	<i>IF YES how many cups?</i> _____	
<i>Sleep Problems</i>	<i>Yes</i>	<i>No</i>		
<i>Weight Problems</i>	<i>Yes</i>	<i>No</i>		

***FAMILY HISTORY***

<i>Family HX</i>	<i>Mother</i>	<i>Father</i>	<i>Mothers Par.</i>	<i>Fathers Par</i>	<i>Siblings</i>
<i>Alcoholism</i>					
<i>Arthritis</i>					
<i>Bleeding Disorder</i>					
<i>High BP</i>					
<i>Kidney Disease</i>					
<i>Bladder Disorder</i>					
<i>Prostate Disease</i>					
<i>Strokes</i>					
<i>Thyroid problem</i>					

<i>Ulcers</i>					
<i>Heart Disease</i>					
<i>Diabetes</i>					
<i>Cancer</i>					
<i>What type of cancer?</i>					

*Name* \_\_\_\_\_ *Date of birth* \_\_\_\_\_

***Past Medical History***

<i>Allergies</i>	<i>Yes</i>	<i>No</i>
<i>Alcoholism</i>	<i>Yes</i>	<i>No</i>
<i>Anemia</i>	<i>Yes</i>	<i>No</i>
<i>Asthma</i>	<i>Yes</i>	<i>No</i>
<i>Blurred Vision</i>	<i>Yes</i>	<i>No</i>
<i>Bronchitis</i>	<i>Yes</i>	<i>No</i>
<i>Cancer</i>	<i>Yes</i>	<i>No</i>
<i>Chest Pain</i>	<i>Yes</i>	<i>No</i>
<i>Depression</i>	<i>Yes</i>	<i>No</i>
<i>Dizziness</i>	<i>Yes</i>	<i>No</i>
<i>Difficulty Swallowing</i>	<i>Yes</i>	<i>No</i>
<i>Drug Abuse</i>	<i>Yes</i>	<i>No</i>
<i>Frequent Infections</i>	<i>Yes</i>	<i>No</i>
<i>Gall Bladder Disease</i>	<i>Yes</i>	<i>No</i>
<i>Gout</i>	<i>Yes</i>	<i>No</i>
<i>Heart Problems</i>	<i>Yes</i>	<i>No</i>
<i>Hepatitis</i>	<i>Yes</i>	<i>No</i>
<i>Irregular Bowels</i>	<i>Yes</i>	<i>No</i>
<i>Nervousness</i>	<i>Yes</i>	<i>No</i>
<i>Nose Bleeds</i>	<i>Yes</i>	<i>No</i>
<i>Pneumonia</i>	<i>Yes</i>	<i>No</i>
<i>Prostate Disease</i>	<i>Yes</i>	<i>No</i>
<i>Sexual Abuse</i>	<i>Yes</i>	<i>No</i>
<i>STD's</i>	<i>Yes</i>	<i>No</i>
<i>Shortness in Breath</i>	<i>Yes</i>	<i>No</i>
<i>Skin Disorders/Rash</i>	<i>Yes</i>	<i>No</i>

<i>Swelling</i>	<i>Yes</i>	<i>No</i>
<i>Ulcers</i>	<i>Yes</i>	<i>No</i>

***Past Surgical History***

*Type of Surgery* \_\_\_\_\_ *Year* \_\_\_\_\_

*Type of Surgery* \_\_\_\_\_ *Year* \_\_\_\_\_

*Type of Surgery* \_\_\_\_\_ *Year* \_\_\_\_\_

*Type of Surgery* \_\_\_\_\_ *Year* \_\_\_\_\_

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*Name* \_\_\_\_\_ *Married* \_\_\_\_ *Single* \_\_\_\_ *Child* \_\_\_\_

*Date of Birth* \_\_\_\_\_ *SS#* \_\_\_\_\_ *Sex* \_\_\_\_\_

*Address* \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip Code* \_\_\_\_\_

*Employer* \_\_\_\_\_ *Spouse Employer* \_\_\_\_\_

*Home Phone* \_\_\_\_\_ *Work* \_\_\_\_\_ *Cell* \_\_\_\_\_

*Email Address* \_\_\_\_\_

***EMERGENCY CONTACT*** \_\_\_\_\_

*Phone* \_\_\_\_\_ *Relation ship* \_\_\_\_\_

***PARENT/GUARDIAN INFORMATION (IF PATIENT IS A MINOR)***

*Name* \_\_\_\_\_ *Date of Birth* \_\_\_\_\_

*Address* \_\_\_\_\_ *City* \_\_\_\_\_

*State* \_\_\_\_\_ *Zip Code* \_\_\_\_\_ *Phone* \_\_\_\_\_ *Cell* \_\_\_\_\_

*Employer* \_\_\_\_\_ *Employer Phone* \_\_\_\_\_

*Primary Insurance* \_\_\_\_\_ *Secondary Insurance* \_\_\_\_\_

*Card Holder* \_\_\_\_\_ *Card Holder* \_\_\_\_\_

Card Holders SS# \_\_\_\_\_ Card Holders SS# \_\_\_\_\_

Card Holders Birthdate \_\_\_\_\_ Card Holders Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

I REQUEST THAT PAYMENT OF AUTHORIZED MIDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE ON MY BEHALF TO MADSEN FAMILY MEDICINE FOR ANY SERVICE FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED THE THE PATIENT. THE PATIENT/PARENT/GUARDIAN IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE A DEPOSIT OF \$112.00 IS DUE AT CHECK IN. I AUTHORIZE MADSEN FAMILY MEDICINE TO RELEASE INFORMATION REGARDING MY HEALTHCARE TO MY INSURANCE COMPANY FOR PAYMENT ON CLAIMS

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(PARENT/GUARDIAN PLEASE SIGN FOR CHILDREN)

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**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

In compliance with the Health Insurance Portability and Accountability Act of 1996 and 45 CFR 164-50B

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_ Phone # \_\_\_\_\_

RELEASE OF MEDICAL RECORDS FROM: \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

RELEASE OF MEDICAL RECORDS TO: \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

( ) Medical Records (Date): \_\_\_\_\_

( ) X-Rays (Reports & Films): \_\_\_\_\_

( ) EKG's (Dates) : \_\_\_\_\_

( ) Labs (Dates): \_\_\_\_\_

( ) Other \_\_\_\_\_

**READ CAREFULLY: Release of confidential Information:**

I ask that all Medical information requested be released to the person or entity named above. I understand that the information is protected by State and Federal confidentiality regulation and that I may revoke my consent at any time, except to the extent that information has already been released in reliance to sexually transmitted diseases including Aids/HIV, Mental Illness, Psychiatrist treatment, and /or drug/alcohol abuse. If I have been tested, treated or diagnosed in connection with any sexually transmitted, or drug/alcohol abuse. And/or mental illness, psychiatrist treatment, you are specifically authorized to release to the person or entity named above all information or medical records relating to such diagnosis, testing or treatment . I understand the subsequent use or dissemination of medical information cannot be limited or controlled by the party whom I request the information be furnished. The request is a free and voluntary act by me. I hereby release all parties from legal responsibility that may arise from the release of the medical information hereby authorized. The release automatically expires 90 days from the date signed.

**PATIENTS SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**IF MINOR, BY PERENT/GUARDIAN** \_\_\_\_\_  
If patient has reached his/her fourteenth birthday **ONLY** the patient may authorize disclosure relating to sexual diseases.