Karing Hearts Cardiology, PLLC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

Street: _____ Patient Phone:_____

City: _____ State: _____ Zip: _____

Emergency Contact_____ Phone_____

Pharmacy_____ Location_____

Referring Physician_____ Primary Physician_____

Patient's Employer _____ Marital Status _____

Do you have health insurance coverage? Yes☐ No☐

If yes, Insurance Name _____ ID# _____

PLEASE BRING INSURANCE CARD

I hereby authorize _____

Primary Care/Specialist

To release information from the medical records of _____

Patients Name

To: *Karing Hearts Cardiology*

Name/Address of Person/Organization to which disclosure is to be made

Phone: *423-926-4468* Fax: *423-928-4838*

For the following purpose: *Cardiac Care*

For treatment dates: _____

Specific dates must be indicated

Type of Access Requested : Records

Description of Information to be used / Disclosed

☐ Cardiac Studies / EKG

☐ Lab

☐ Operative / Procedure Report

☐ Radiology

☐ Other _____

Expiration Date: ____/____/____ OR Expiration Event: _____

(Note: Date or Event not to exceed 90 days from date of signature)

_____ I acknowledge, and hereby consent to such, that the released information may contain psychiatric, alcohol, drug abuse, HIV testing, HIV results, or AIDS information.

Initials

I understand that I may revoke this authorization at any time by notifying in writing the Medical Record Department of Karing Hearts Cardiology, PLLC. Such notice will not have any effect on any actions already made prior to this authorization. I understand that my healthcare, payment for my healthcare, enrollment or eligibility of benefits will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

_____ _____ _____

Date Signature of Patient/Parent/Conservator/Guardian Relationship to Patient

Fees/charges will comply with all laws and regulations applicable to release of information

Over →

AUTHORIZATION FOR RELEASE OF PATIENT'S INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION TO DPR, TO VOICEMAIL/ANSWERING MACHINE. OR BY E-MAIL

This Authorization grants permission to the Designated Party(ies) named below to: make or confirm appointments; have access to x-ray, laboratory, or test findings; have access to telephone communication and answering machine messages, as well as other common means of communication; pick up sample medications; be made aware of my diagnosis, prognosis, and treatment plans; and have access to my financial health information. Unless otherwise noted below, this Authorization grants Karing Hearts Cardiology permission to leave messages on my answering machine/voicemail and/or to contact me by e-mail using my protected health information pertaining to; scheduling or confirming appointments, information related to x-ray, laboratory, or test/procedure findings, information deemed appropriate/necessary by health care provider(s). I understand that by giving Karing Hearts Cardiology my e-mail address, I am granting my permission for Karing Hearts Cardiology to contact me through e-mail regarding my PHI.

My e-mail address is: _____

( ) Please *do* not leave messages on my answering machine ( ) Please do not contact me by e-mail

I hereby authorize Karing Hearts Cardiology to use/disclose my individually identifiable health information as described above to the parties named below. I understand that this authorization is voluntary. I understand that once this information is released, it may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: _____ SSN: _____

Designated party _____ Relationship to patient _____

Address _____ phone _____

Designated party _____ Relationship to patient _____

Address _____ Phone _____

The information will be used or disclosed for the following purposes:

_____ At the request of the individual other _____

Please read the three statements below carefully before signing this document:

1. I understand that I may revoke this Authorization at any time by notifying Karing Hearts Cardiology in writing; however, if I do revoke the Authorization, it will not have any effect on any actions taken in reliance upon the Authorization by Karing Hearts Cardiology prior to their receipt of the revocation.

2. I understand that my treatment cannot be conditioned on whether or not I sign this Authorization.

3. I understand that this Authorization will: **(Must check one)**

( ) be effective for the lifetime of the patient unless revoked OR **( )** expire 1 year from the date executed.

Signature of patient or representative _____ Date _____

* YOU MAY REFUSE TO SIGN THIS AUTHORIZATION *

I acknowledge that I have received information about HIPPA and my rights to privacy from Karing Hearts Cardiology PLLC.

_____

Patient signature Date

_____

Witness Signature Date

Karing Hearts Cardiology: Patient History

Name: _____

Date of Birth: _____

Medicine Allergies: Check/Write ALL that Apply

Shrimp ☐ **Shellfish** ☐ **Iodine** ☐ **Contact Dye** ☐ **Penicillin** ☐ **Other:**_____

Cardiac History: Please Check/Write ALL that Apply

CAD		
Heart Catheterization ☐ Year _____	Angioplasty/Stent/Rotoblator ☐ Year _____	Bypass Surgery ☐ Year_____
Arrhythmia		
Atrial Fibrillation ☐ Year Diagnosed _____	Elective Cardioversion ☐ (Shock to Restore Normal Rhythm) Year _____	Pacemaker/Defibrillator ☐ Year _____
PVD		
TIA (Mini Stroke) ☐ Year _____	Surgery/Stent to Arteries in Neck ☐ (Carotids)/Legs/Kidney Year _____	Aneurysm ☐ Year _____
Valvular		
Valve Disease ☐ Year _____	Heart Valve Surgery ☐ Year _____	Which Valve? _____

Cardiac Risk Factors: Check/Write ALL that Apply

Do you use tobacco(cigarettes/smokeless)? Yes ☐ No ☐ Former ☐

How Many Packs per Day _____ For how many years_____ Date that you Quit? _____

Diabetes Mellitus Yes ☐ No ☐ Juvenile ☐ Adult ☐ How long _____

High Blood Pressure? Yes ☐ No ☐

High Cholesterol? Yes ☐ No ☐

Has Anyone in your Immediate Family had Heart Disease before age 60? If so, who? _____

Social Family History: Check/Write ALL that Apply

Number of Children: _____Sons _____Daughters

Alcohol Consumption: Rarely ☐ Occasionally ☐ Often ☐ Never ☐

Occupation: _____ Disabled ☐ Retired ☐ Still Working ☐

Over →

Name: _____

Past Medical History: Check/Write ALL that Apply

Have you ever been diagnosed with any of the following?

☐Abdominal aortic aneurysm	☐Coronary artery disease	☐Occlusive disease artery
☐Acute Coronary Syndrome	☐Coronary artery embolism	☐Osteoporosis
☐Allergies	☐Coronary artery stenosis	☐Peptic ulcer disease
☐Anemia/Iron deficient	☐Coronary artery thrombosis	☐Pulmonary valve disorder
☐Aneurysm of coronary vessels	☐Depression	☐PVD/Peripheral vascular disease
☐Angina/chest pain	☐Diabetes	☐Renal disease
☐Anxiety	☐Elevated lipids	☐Seizure disorder
☐Arthritis	☐GERD -Gastroesophageal Reflux Disease	☐Stroke
☐Asthma	☐Headache, migraine	☐Thyroid disease
☐Blood clots	☐Heart murmur	☐Valvular disease
☐Cancer	☐Hepatitis/liver disease	☐Other…
☐Cardiac arrhythmia	☐Hypertension	☐Other…
☐Cardiovascular disease	☐Irritable bowel disease	
☐Carotid artery stenosis	☐Ischemic heart disease	
☐COPD	☐Myocardial infraction	

Surgical History

Have you ever had the following surgeries?

☐Angioplasty	☐Hernia Repair
☐Appendectomy	☐Hip replacement
☐Back surgery	☐Hysterectomy
☐Blood transfusion	☐ICD insertion
☐CABG – Open heart surgery	☐Mastectomy
☐Cardiac pacemaker	☐ Joint surgery
☐Carpal tunnel release	☐Thyroidectomy
☐Cataract extraction	☐Tonsillectomy
☐Cholecystectomy	☐Other…
☐Dialysis	☐Other…

Karing Hearts Cardiology

Vascular Risk Assessment

Name: _____ **Date of Birth**: _____**Date:** _____

Circle **"Yes"** or **"No"** to determine if a vascular exam will help better access your leg health.

At the end of the day:

1.	Are your legs swollen, painful, red or warm to the touch?	Yes	No
2.	Do your legs feel heavy, tired, restless or achy?	Yes	No
3.	Do you get pains from prolonged sitting or standing?	Yes	No

Other Symptoms:

4.	Have you had a blood clot in a vein that caused inflammation, pain or irritation?	Yes	No
5.	Do you have varicose veins, ropey or bulgy veins (raised above? the skin surface) in the legs?	Yes	No
6.	Do you suffer from tingling, numbness, burning or cramping in the legs or feet?	Yes	No
7.	Do you have skin discoloration on your lower legs?	Yes	No
8.	Do you have hard to heal ulcers or sores on your lower legs?	Yes	No
9.	Do you have a family history of blood clots?	Yes	No
10.	Have you had a DVT (Deep Vein Thrombosis) in the past?	Yes	No
11.	If female, have you had one or more children?	Yes	No
12.	Throughout the day do you have to stop, rest or elevate your legs to complete daily tasks?	Yes	No
13.	Have you tried leg elevation, oral pain medication or compression stockings to help relieve symptoms?	Yes	No

Please indicate any activities of daily living that are affected by your condition (ex. Working, driving, shopping etc.): _____

Clinical Notes: _____

_____

Diagnostic Recommended: **Yes** ☐ **No** ☐

_____

Provider Signature

Over →

Please list below all medications you are currently taking:

	Medication Name	Dosage	Frequency Taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			