ALLIANCE
COMMUNITY HEALTHCARE, INC.

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

Medical Assessment

1. Has there been any change in your health in the past year?

   _____

   _____

   _____

2. My last physical exam: _____
3. Are you under the care of a physician? Yes or No
   a. If so, what condition is being treated? _____
4. Have you had any serious illnesses, operations or been hospitalized within the past 5 years?

   _____

   _____

   _____

5. Are you taking any medicine(s) including non-prescription medicine? Yes or No

   If yes, what medications (name and dosage):

   _____

   _____

   _____

6. Do you have any allergies? Yes or No

   If yes, please explain: _____
7. Are you allergic or have you had any reaction to local anesthetics? Yes or No

a. Novocain? Yes or No

b. Penicillin or other antibiotics? Yes or No

c. Sulfa Drugs? Yes or No

d. Barbiturates, sedatives, sleeping pills? Yes or No

e. Aspirin? Yes or No

f. Iodine? Yes or No

g. Codeine or other narcotics? Yes or No

8. Do you have any chronic diseases? Yes or No

a. Asthma or Hay Fever? Yes or No

b. Diabetes? Yes or No

i. In the past 12 months, did a dentist, hygienist or other dental professional have a direct conversation with you regarding the dental benefits of checking your blood sugar? Yes or No

c. Hepatitis, jaundice or liver disease? Yes or No

d. AIDs or HIV? Yes or No

e. Thyroid Problems? Yes or No

f. Respiratory problems such as emphysema or bronchitis? Yes or No

g. Arthritis or painful swollen joints? Yes or No

h. Stomach ulcer or hyperactivity? Yes or No

i. Kidney trouble? Yes or No

j. Tuberculosis? Yes or No

k. Persistent cough or cough that produces blood? Yes or No

l. Persistent swollen glands in neck? Yes or No

m. Low blood pressure? Yes or No

n. High blood pressure? Yes or No

o. Cardiovascular Disease:

(Heart Trouble, Heart Attack, Angina, Coronary Insufficiency?) Yes or No

i. Do you have chest pain on exertion? Yes or No

ii. Are you ever short of breath after mild exercise or while laying down?

Yes or No

iii. Do your ankles swell? Yes or No

iv. Were you born with any heart defects? Yes or No

Do you have a cardiac pacemaker? Yes or No

p. Epilepsy or other neurological disease? Yes or No

q. Problems with mental health? Yes or No

r. Problems with immune system? Yes or No

s. Cancer? Yes or No

Women Only:

Are you pregnant or think you may be pregnant? Yes or No

Are you breastfeeding? Yes or No

Are you taking birth control pills? Yes or No

Please List all doctors and Specialists who currently prescribe your medications:

Dr. _____ may be reached at _____
Treating me for _____

Dr. _____ may be reached at _____
Treating me for _____

Dr. _____ may be reached at _____
Treating me for _____

Dr. _____ may be reached at _____
Treating me for _____

I authorize Alliance Community Healthcare to reach out for all medical records, including labs, diagnostic Studies and consultation notes for the last 3 visits.

Patient Signature: _____ Date: _____

ALLIANCE
COMMUNITY HEALTHCARE, INC.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ **MR#:** _____

DOB:_____ **Social Security #:** _____ **Phone:** _____

Home Address: _____

1. **TYPE OF REQUEST:** I hereby request that Alliance Community Healthcare provide me with:

☐ **Access to Review Originals** ☐ **Photocopies of my Health Information, as requested below**
(Alliance Community Healthcare may provide a written summary in lieu of access to the originals or photocopies, but only if I agree to this option and the related fees)

2. **INFORMATION TO BE RELEASED** (include discharge date(s), date(s) of service etc.)

_____

3. **DESCRIPTION OF INFORMATION TO BE RELEASED** (check all that apply)

☐ Entire Medical Record	☐ History and Physical	☐ Operative Reports	☐ Billing Records
☐ ER Record Only	☐ Progress Notes	☐ X-Rays	☐ ALL Records
☐ Outpatient Record Only	☐ Consultation Reports	☐ EKG/EEG	☐ Other (specify)
☐ Discharge Summary	☐ Pathology Results	☐ Labs	_____

4. **SPECIFIC CONFIDENTIAL INFORMATION AUTHORIZED FOR RELEASE:**
By signing my initials next to the specific category of highly confidential information, I am authorizing Alliance Community Healthcare to release the indicated type of information next to my initials pursuant to this Authorization from the treatment date(s) listed above.

____ HIV/AIDS Related Information	____ Sexually Transmitted Disease Information
____ Mental Health and Psychotherapy Information	____ Genetic Information
____ Drug and Alcohol Information	____ Tuberculosis Information

5. **RELEASE INFORMATION TO:**
☐ Myself (the patient or representative) ☐ The organization described below

Organization Name: _____
Phone: _____ Fax: _____
Address: _____

☐ Please Mail ☐ Please Fax ☐ Please prepare for pick-up ☐ Please publish to the patient portal

6. **PURPOSE OF RELEASE**: I authorize Alliance Community Healthcare to release my health information for the following specific purpose: _____

7. **TERM/AUTHORIZATION** This signed authorization will automatically expire within one year from the date of signature. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department at Alliance Community Healthcare. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. **FEES** (apply to photocopies provided to the patients and their legally authorized representatives only; other fees may apply to other requestors): I understand that Alliance Community Healthcare is permitted under state and federal laws to charge me a fee for photocopies of my medical records and any applicable mailing/postage fees. I further understand that under New Jersey law, the fees are based on the actual costs and may not exceed $1.00 per page or $100.00 per record (for the first 100 pages) and $0.25 per page thereafter up to a maximum of $200 per record. A search fee of no more than $10.00 per patient request may also be charged. If applicable, a fee for a written summary in lieu of photocopies of the original records may be obtained for $ _____.

I understand that any information provided to me pursuant to this request will not include information compiled in reason -able anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law.

I understand that Alliance Community Healthcare may deny this request under limited circumstances as provided for under federal and state law protecting privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Alliance Community Healthcare who did not participate in the Alliance Community Healthcare decision to deny my request. These and other actions are included in Alliance Community Healthcare's Notice of Privacy Practices.

I understand that Alliance Community Healthcare will notify me of its decision to approve or deny my request to access or obtain a copy of my Requested health information within thirty (30) days of receiving this request if the information is maintained or accessible on site at Alliance Community Healthcare. If Alliance Community Healthcare is unable to comply with my approved for my health information maintained or accessible on-site within thirty (30) days, it may extend the applicable deadline for up to thirty (30) more days by notifying me in writing.

The information to be disclosed from your records is confidential and is protected by federal and state law. I understand that once Alliance Community Healthcare releases my health information to the recipient listed on this Authorization, Alliance Community Healthcare cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand I will be provided a copy of my signed Authorization, and that Authorization will remain in effect until the term of this Authorization expires or I provide a written revocation to Alliance Community Healthcare's Privacy Officer at the address listed below. The revocation will be effective immediately upon Horizon's receipt of my written notice, except that the revocation will not have any effect on any action taken by Alliance Community Healthcare in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this request and I have had the opportunity to ask questions about my rights to access my health information and any protected Health Information (PHI) that Alliance Community Healthcare uses to make medical decisions about me. I also understand that if I have further questions or concerns regarding my Protected Health Information, I may contact Alliance Community Healthcare's Privacy Officer by mail at Alliance Community Healthcare, 714 Bergen Avenue, Jersey City, NJ 07306; or by telephone at 201-451-6300.

I hereby authorize Alliance Community Healthcare to release/disclose the health information listed above for the purposes described in this Authorization.

Patient Signature: _____ Date: _____

If the patient is a minor or otherwise unable to sign this Authorization, then obtain the signature of the authorized representative/individual below:

Description of Authority: _____

Signature: _____ Date: _____ (Other than patient)