

120 Memorial Dr
Jacksonville, NC 28546



Jacksonville Children's and Multispecialty Clinic, P.A.

Phone (910)353-0581/9688
Fax (910)353-1536/7498

Authorization for Release of Information

Name of Patient _____ DOB _____

Address _____ City _____ State _____ Zip _____

Name and address of covered entity authorized to release information:

Jacksonville Children's and Multispecialty Clinic, P.A.
120 Memorial Dr
Jacksonville, N.C. 28546

The above named entity is authorized to disclose protected health information to the entities name below.

Entity to receive information (**Initial each that is subject to this authorization**)

- _____ Leave information on the voice mail
- _____ Leave information with my spouse (name) _____
- _____ Leave information with the following individual(s) (name(s)) _____
- _____ Leave information **only** with myself or personal representative

Description of information to be released

- _____ Date & time of my next appointment and with whom
- _____ Information results from any tests or x-rays
- _____ Reminder notification for annual exam
- _____ Other information as described: _____

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization. The permitted use of the information is to inform the patient.

I understand that I have the right to revoke this authorization at any time by sending written notification to the Release of Information clerk at the above address.

I understand that my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

Signature of Patient or Personal Representative _____ Date _____

Print name of Patient or Personal Representative

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Name: _____ DOB: ___/___/____ Today's Date: ___/___/____

List any known allergies: _____ Date of last Tetanus shot: ___/___/____

Emergency contact: Name _____ Phone: _____ Relationship: _____

Do you have a living will? _____

Check if you currently have, or indicate the date, if you have ever had any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other Psychiatric Disorder | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Positive TB Test | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Cholesterol | | |

of Pregnancies: _____ # of Deliveries: _____ # of Miscarriages: _____ # of Abortions: _____

Complications: _____

Date of last physical exam (and/or pap smear):

Hospitalizations (Date, Reason, Outcome):

Surgeries (Date, Types):

Fractures, Serious Injuries:



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Occupation: _____ Check if exposed to: Heavy Lifting Hazardous Substances

Stress

Check which substances you use, describe the quantity:

Tobacco _____ Alcohol _____ Caffeine _____ Drugs _____

Pharmacy Name: _____ Phone Number: _____

List all medication you are currently taking, including dosage:

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Family History:

Relation	Age	State of Health	Age of Death	Cause of Death	Check if blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer, Type: _____	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
					High Blood Pressure	
Sisters					Kidney	
					Tuberculosis	
					Other	
Children						

Other information you feel is important for the doctor to know about you:

 Patient Signature

 Date

