Memorial Healthcare System

DIVISION OF THORACIC SURGERY

Communication Form:

Best Phone to call: _____ **type/relationship** _____

Next Best phone #: _____ **type/relationship**_____

Next Best Phone#: _____ **type/relationship** _____

Email address: _____

May we leave a message on your answering machine/voice mail ?

☐ YES ☐ NO

We cannot release your medical information to anyone without your written permission (except to other health care providers that are providing you treatment, and to insurance companies to obtain payment for services we provide to you, per HIPPA Guidelines).

Who may we release medical information to - Non-physician?

Name: _____ **Relationship** _____

Name; _____ **Relationship** _____

Name: _____ **Relationship** _____

PRINT NAME _____

SIGNATURE _____

DATE _____

Memorial Healthcare System

DIVISION OF THORACIC SURGERY

PERSONAL MEDICAL HISTORY FORM

Name: _____ Date of Visit: _____

Reason for Visit: _____

Please list all your physicians:

Specialty	Physician Name	City	Phone #
Primary Care / Internal Medicine			
Pulmonary			
Cardiology			
Oncology			
Gastroenterology			

_____

For office use only:

Memorial Regional Hospital

DIVISION OF THORACIC SURGERY
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

PATIENT NAME _____ DOB _____

_____ DOS _____

(PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE)

hereby authorizes: _____ to disclose medical records obtained in the course of my diagnosis and/or treatment per my request. This information is to be released to:

_____ _____ _____

(NAME) (STREET ADDRESS) (CITY/STATE/ZIP)

and is to be used for the following purpose: (state reason records are needed): _____

_____

and such disclosure shall be limited to the following specific types of information:

____ Complete Records ____ History and Physical Exam

____ Consultation Report: date _____

____ Other: _____

_____

I, hereby release Memorial Hospital, Hollywood, Fl. and/or Memorial Hospital West, Pembroke Pines, Fl. from any liability which may result from this release of confidential medical records or which may arise as a result of the use of the information contained in the records released; and as such, I relieve and hereby agree to hold Memorial Hospital and/or Memorial Hospital West and the above named parties free and harmless from any and all liability arising out of this release. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon, and if not earlier revoked, this consent will automatically expire after the requested information has been provided. Should you require actual x-ray files, you must obtain them from the Radiology Department.

_____ _____

(Parent, Guardian or Personal Representative of Patient) (Date)

Witness: _____ Date: _____