Dr. Dominick Carbone

YADKIN VALLEY UROLOGY

200 Johnson Ridge Medical Park, Elkin, NC 28621

Phone: 336-526-0040 Fax: 336-526-0043

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, do hereby consent and authorize _____ to release to *YADKIN VALLEY UROLOGY* my medical records relating to my identity, diagnosis, prognosis and treatment, including but not limited to treatment of drug and alcohol related illness, psychiatric treatment, diagnosis and/or treatment of HIV related illness, sickle cell disease, or hepatitis. I understand the extent or nature of the medical information to be disclosed includes:

☐ All medical records ☐ other: _____

I also understand that the purpose of this disclosure is to obtain medical information for medical care provided to me by *YADKIN VALLEY UROLOGY.*

Furthermore, I understand that this authorization is revocable by me at any time I provide a written and signed notice of the revocation to *YADKIN VALLEY UROLOGY*, except to the extent that any action has been taken on this release. Otherwise, this consent will remain in force for 90 days.

Special request/instructions: _____

_____.

Signature of Patient: _____ _____

Signature of parent/legal guardian: _____

Patient date of birth: _____/_____/_____

Witnessed by: _____ of *Yadkin Valley Urology*

Date signed: ___/___/___

YADKIN VALLEY UROLOGY – Patient Registration

Patient **FULL** name	Mailing address
Date of birth	Social Security #
Home phone #	Work phone #
Cell phone #	Employer
Family doctor	Pharmacy of choice
Please check the box for the appropriate response: ☐ Single ☐ Divorced ☐ Widow ☐ Married *__Please write the name of your spouse below__: Please provide your email address:	Contact information for your spouse: Work phone # (_____) _____ - _____ Cell phone # (_____) _____ - _____

Write NO in the space above if you do not have an email you wish to provide.

Emergency Contacts

Name Relationship to patient:	Name Relationship to patient:
Home phone #	Home phone #
Work phone #	Work phone #
Cell phone #	Cell phone #

Assignment of Benefits:

I hereby assign payment directly to Yadkin Valley Urology of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered. I understand that if any balance remains after insurance processes, I will be responsible to pay this.

Release of Information:

I hereby authorize Yadkin Valley Urology to release medical information as may be required by any insurance company concerned with payment of benefits for me. I further authorize Yadkin Valley Urology to release medical information to any facility or physician to whom I am referred. These authorizations shall remain in effect until I provide written notice revoking them.

Privacy Notice:

I acknowledge that I have received the Yadkin Valley Urology Privacy Notice as required by the Health Insurance Portability and Accountability Act [HIPPA]. In compliance with the Health Insurance Portability and Accountability Act [HIPPA] of 1996, and to protect all patients and their right to privacy of all medical records, the following policy has been established. ***YADKIN VALLEY UROLOGY*** will only release medical information to the person you have authorized to obtain these results. Unless specified this release includes all information [including labs, x-rays, and other medical tests] of any kind.

Patient Signature → _____ Date: _____/____/_____

Patient Name: _____

Medical Allergies

Check all that apply: Codeine ☐ Bee Sting ☐ Sulfa ☐ Penicillin ☐ No known drug allergies ☐

Other allergies

_____

Please check which one applies to you → ☐ **Smoker** ☐ **Non-smoker** ☐ **Previous smoker [quit]**

Alcohol: ☐ **Yes or** ☐ **No**

Illegal Substance Use: ☐ **Yes or** ☐ **No**

CURRENT MEDICATIONS **IF you have a list, please check here →** ☐ **We will copy your list, so you won't have to do this part.**

Name of Medicine	**Dosage**	**How many times per day?**

[IF more space is needed, please write on the back of this form.]

Medical History Place a check in the box to the left of any medical condition you have had in the past:

☐ Aneurysm	☐ Asthma
☐ Blood problem – anemia	☐ Bronchitis
☐ Cancer – specify what kind:	
☐ COPD	☐ Crohn's disease
☐ Diabetes – please state if you are on: ____ diet control	____ oral medication/ insulin
☐ Arthritis	☐ Gall bladder disease
☐ Glaucoma	☐ Heart disease
☐ Hepatitis	☐ Hernia
☐ High blood pressure [hypertension]	☐ High cholesterol
☐ IBS – irritable bowel syndrome	☐ Migraine headaches
☐ Prostate problems [including cancer]	☐ Renal failure
☐ Renal [kidney] stones	☐ Stroke
Other [not listed above]:	
☐ ***FAMILY HISTORY OF KIDNEY STONES***	☐ ***FAMILY HISTORY OF PROSTATE CANCER***

Surgical History Please place a check in the box to the left of any surgery you have had:

☐ Appendectomy	☐ Back surgery
☐ Bladder surgery – please indicate type of surgery:	
☐ Breast surgery	☐ D & C
☐ Gall bladder surgery	☐ Hemorrhoid surgery
☐ HEART surgery – please indicate what you have had: [ex: bypass]	☐ Hernia repair – please indicate where the hernia was:
☐ Hip replacement	☐ Hydrocele repair
☐ Hysterectomy	☐ Kidney stone surgery
☐ Limb surgery –EX: arm, hand, leg, elbow, knee, foot:	
Other [not listed above]:	

Yadkin Valley Urology

An Affiliate of Hugh Chatham Memorial Hospital

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under the HIPAA regulations we are not allowed to give any medical or billing information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must complete this form. Signing this form will only give consent to release this information to the family members indicated below.

You have the right to revoke this consent in writing.

I authorize/allow Yadkin Valley Urology to release my medical and/or billing information to the following individual(s):

1. _____ Relation to patient: _____
2. _____ Relation to patient: _____
3. _____ Relation to patient: _____
4. _____ Relation to patient: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE MESSAGES WITH HOUSEHOLD MEMBERS/ANSWERING MACHINE;

Occasionally it is necessary to leave messages for patients to remind them of an appointment, to notify the patient that the staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of this office discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____