STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name Date of Birth

Address

Area Code & Telephone Number City State Zip

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Clinic, Inc to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Clinic, Inc as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations Authorized to Receive My Information:

(Name, Address, Phone & Fax) Relationship Purpose

_____

_____

_____

_____

Information to be shared

1. Check one or more boxes below.

- ☐ Entire Medical Record (includes all records except Psychotherapy Notes)
- ☐ Psychotherapy Notes
- ☐ Mental Health Records

☐ Pathology Report	☐ History and Physical	☐ Operation Report(s)
☐ Progress Notes	☐ Consultation Report(s)	☐ Discharge Summary
☐ EKG Report(s)	☐ Laboratory Report(s)	☐ Radiology Report(s)
☐ Physician's Orders	☐ Radiology Films	☐ Alcohol or Drug Abuse Records

☐ Other

2. Covering Services Between _____ and _____ (Insert either date(s) or "all.")

IV. EXPIRATION & REVOCATION

A. This Authorization will Expire (**must choose one**):

☐ 3 years after last office encounter ☐ Other (insert date or event): _____

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B. Right to Revoke

I understand I may change this authorization at any time by writing to the address listed at the bottom of this form. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

3. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to the address listed at the bottom of the form.

4. I understand Norman Clinic, Inc, as a member of Oklahoma Physician Health Exchange (OPHX), may utilize an electronic network to exchange my protected health Information with other providers unless I choose not to participate.

5. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

B. Signature

This document must be signed by the individual or the individual's legal representative.

Signature (Patient or Legal Representative) Date

_____

Printed Patient or Legal Representative Name Capacity of Legal Representative (if applicable)

_____

Physician / Clinic Address: Norman Clinic
950 North Porter Avenue
Norman, Oklahoma 73071

Health Maintenance Questionnaire

Name: _____ DOB: _____ Date: _____

Health Habits:

1. Do you smoke?..... ☐ Yes ☐ No
   if yes, how much per day?_____
2. Do you drink alcoholic beverages?..... .. ☐ Yes ☐ No
   if yes, how much per day?_____
   or per week?_____
3. Are you following any special diet?..... ☐ Yes ☐ No
4. Are you performing regular exercise? . ☐ Yes ☐ No
   if yes, what type of exercise, how long,
   and how often?_____
   _____
   _____
5. Are you taking any herbal medicine
   products?..... ☐ Yes ☐ No
   If yes, please list: _____
   _____

Preventative History:

Has anyone in your family developed a hereditary medical problem since your last appointment?..... ☐ Yes ☐ No
If yes, please list: _____

Preventative Health Checkups:

1. When was your last testing for blood in your stool?_____ __
2. When was your last sigmoidoscopy or colonoscopy ?_____
3. When was the last time your cholesterol level was checked? _____
4. When was the last time you had fasting blood sugar taken ? _____
5. Has your thyroid function ever been tested?..... ☐ Yes ☐ No
6. When was your last:
   Tetanus vaccination? _____
   Pneumonia vaccination? _____

Female:

1. When was your last mammogram? _____
2. Do you do monthly breast exams? …… ☐ Yes ☐ No
3. When was your last pelvic examination and Pap smear? _____
4. When was you last bone mineral density test performed? _____

Male:

1. When was your last:
   Digital rectal examination? _____
   PSA (prostatic specific antigen) taken? _____

Review of Health Habits:

1. Have you had any change in appetite? ..... ☐ Yes ☐ No
2. Have you had any change in weight? …….. ☐ Yes ☐ No
3. Have you had any nasal congestion, sneezing or drainage?..... ☐ Yes ☐ No
4. Any change in hearing?..... ☐ Yes ☐ No
5. Any change in your vision?..... ☐ Yes ☐ No
6. Have you had any problems with:
   Cough?..... ☐ Yes ☐ No
   Sputum production?..... ☐ Yes ☐ No
   Shortness of breath?..... ☐ Yes ☐ No
   Pleurisy?..... ☐ Yes ☐ No
7. Have you had any problems with:
   Chest pain?..... ☐ Yes ☐ No
   Palpitations?..... ☐ Yes ☐ No
   Swelling?..... ☐ Yes ☐ No
8. Have you had any problems with:
   Nausea?..... ☐ Yes ☐ No
   Vomiting?..... ☐ Yes ☐ No
   Heartburn?..... ☐ Yes ☐ No
   Difficulty swallowing?..... ☐ Yes ☐ No
   Diarrhea?..... ☐ Yes ☐ No
   Abdominal pain?..... ☐ Yes ☐ No
   Blood in your stools?..... ☐ Yes ☐ No
9. Have you had any problems with:
   Muscular weakness?..... ☐ Yes ☐ No
   Numbness ?..... ☐ Yes ☐ No
   Joint pains ?..... ☐ Yes ☐ No
10. Do you get up at night to urinate?..... ☐ Yes ☐ No
    If yes, how many times per night? _____
11. Have you had any problems with:
    Urinary incontinence ? ……..…. ☐ Yes ☐ No
    Blood in the urine? ……..…… ☐ Yes ☐ No
    Painful urination? …….. ☐ Yes ☐ No
    Increased urinary frequency? ……..…… ☐ Yes ☐ No
12. Do you have any rashes or abnormal-appearing skin lesions? ……..…. ☐ Yes ☐ No
13. Have you been:
    Anxious? …… ☐ Yes ☐ No
    Depressed? …… ☐ Yes ☐ No
14. Have you had any problems with:
    Memory loss? ……..…… ☐ Yes ☐ No
    Confusion? …… ☐ Yes ☐ No
15. Do you have problems tolerating heat or cold? …… ☐ Yes ☐ No
16. Do you have problems with excessive thirst? …….. ☐ Yes ☐ No

Name: _____ DOB: _____ Date: _____

MEDICAL: Please list any serious past or ongoing medical problems for which you have been or are currently being treated.

1. _____
2. _____
3. _____
4. _____
5. _____

SURGICAL: Please list any surgeries you have had performed either in or out of the hospital.

1. _____
2. _____
3. _____
4. _____
5. _____

OBSTETRICS / GYNECOLOGICAL:

1. Pregnancies: _____
2. Deliveries:
   a. By vaginal delivery: _____
   b. By cesarean section: _____
3. Age at first period: _____
4. Age at menopause (if applicable): _____
5. Do you take hormone replacement therapy? ____
   If you stopped, when and why? _____
   _____

CURRENT MEDICATIONS:

Name	**Dosage**	**How often taken?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

MEDICATION ALLERGIES: _____

FAMILY HISTORY: Please list any past or ongoing health problems for the following familty members.

Father: _____
Mother: _____
Brothers / Sisters: _____
Grandparents: _____