Hammond-Henry Hospital
Medical Group

Today's Date: ____/____/____

❑ Geneseo ❑ Cambridge ❑ Kewanee ❑ Port Byron

New Patient Questionnaire

Patient Information				
Legal Name Last	First	M.I.	Date of Birth	S.S. #:
Address	City		State	Zip Code
Primary Phone Number		Driver's License #:		
Who do you want as your new primary care provider/doctor?				
Who was your previous primary care provider/doctor?				
Is there a family member that is currently a patient here?				
Reason for appointment?				
Medical History/Main Medical Concerns:				

OFFICE USE ONLY

❑ Yes ❑ No

_____ _____

Physician/Providers Signature Date

Hammond-Henry Hospital
Medical Group

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I,_____, _____
(Name) (Date of birth)

authorize,_____, to disclose the following information
(Name of Institution)

to Hammond-Henry Hospital Medical Group: ❑ Geneseo ❑ Cambridge ❑ Kewanee ❑ Port Byron
(Person Receiving the Information)

for the purpose of _____
(Continued Care, Legal Proceedings, Insurance Billing)

Medical records or other information regarding my treatment, hospitalization, and/or outpatient care.

- ❑ History & Physical, Consultations
- ❑ Operative Reports, Discharge Summary
- ❑ Lab, X-Ray, EKG, EEG, Testing, etc.
- ❑ Other _____
- ❑ Psychological Evaluation
- ❑ Psychological Examination
- ❑ Entire Record

This information is for the hospitalization and/or outpatient visit from:_____ to _____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), psychological or psychiatric impairments, substance abuse, child abuse, spousal abuse, elderly abuse, rape, or adoption.

I understand this information may be re-disclosed by the person(s) receiving it and no longer protected by the federal privacy regulations.

I understand that I may revoke this authorization at any time by giving written notice to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization or to information required by the Privacy regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

I understand the medical record is protected under the Federal Confidentiality Regulation and cannot be disclosed without the patient's written consent unless otherwise provided for in the regulations.

I understand that I may request to inspect the information to be released.

I understand this authorization shall automatically expire without my expressed revocation 90 days from the date of signing or on_____.

_____ _____
Signature of patient or Legal Representative Date

_____ _____
If signed by Legal Representative, relationship Signature of witness

RELEASE

Geneseo: 600 North College Avenue | Geneseo, Illinois 61254-1099 | Phone: (309) 944-1275 | Fax: (309) 944-9200
Cambridge: 106 North East Street | Cambridge, Illinois 61238 | Phone: (309) 937-3560 | Fax: (309) 937-3565
Kewanee: 1258 West South Street | Kewanee, Illinois 61443 | Phone: (309) 853-3677 | Fax: (309) 853-3692
Port Byron: 105 North Main Street | Port Bryon, Illinois 61275 | Phone: (309) 523-2015 | Fax: (309) 523-9025

Hammond-Henry Hospital
Medical Group

Today's Date: ____/____/____

❑ Geneseo ❑ Cambridge ❑ Kewanee ❑ Port Byron

Patient Information

Patient's Legal Last Name First M.I.:			Marital Status: ❑ Sgl ❑ Div ❑ Sep ❑ Mar ❑ Wid	Date of Birth / Age
Patient's Social Security Number (If not a minor):	Email			Sex: ❑ Male ❑ Female
Patient's Primary Phone Number	Secondary Phone Number			
Patient's Address (Permanent)	City	State	Zip Code	
Patient's Address (Temporary)	City	State	Zip Code	
Patient's Employer / Employer Address / City / State / Zip Code			Work Number	Occupation
Spouse/Parent's Name	Social Security Number	Date of Birth	Work Number	Occupation
Spouse/Parent's Employer	Employer Address / City / State / Zip Code			
Spouses Address (if divorced or separated	Spouse Address / City / State / Zip Code			Phone Number

Authorization for Release of Protected Health Information

I, _____, herby authorize the following person(s) to receive medical information on my behalf:

Name _____	Name _____
Address _____	Address _____
Phone # _____	Phone # _____
Relationship _____	Relationship _____

Medical information may include test results such as labs, x-rays, and other tests and information from office visits. This will not include information concerning mental health or HIV testing, pregnancy, or gynecological issues. Any information requested must be known by the patient and he/she must be aware that the above-named person(s) are acquiring this information.

Signature: (X) _____ Date: _____ Time: _____

Authorization for Release of Protected Health Information Updates

Signature	Date	Signature	Date

Authorization for Agent to Consent to Medical Treatment of a Minor

I hereby authorize _____ (an adult into whose care the minor has been entrusted) to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of _____ (name of minor) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided. This authorization is made under Civil Code 25.8.

Signature: (X) _____ Date: _____ Time: _____

Consent for Treatment of a Minor Updates

Signature	Date	Signature	Date

_____ _____ _____

Signature of Witness Date Time

❑ Interpreter Used _____

Interpreter ID# and/or Interpreter Service Used