

# OPEN MRI of S.A.N.P.C

## CONFIDENTIAL PATIENT INFORMATION SHEET

DATE: \_\_\_\_\_ PRIMARY OR REFERRING DOCTOR: \_\_\_\_\_  
DOCTOR PHONE # \_\_\_\_\_

IS YOUR VISIT RELATED TO AN ACCIDENT? \_\_\_\_ YES \_\_\_\_ NO

IF YES, WHAT KIND OF ACCIDENT? \_\_\_\_\_ AUTO \_\_\_\_\_ WORKER'S COMP

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

RESPONSIBLE PARTY (IF A MINOR): \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

HOME PHONE#: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: ( ) M ( ) F SOCIAL SECURITY #: \_\_\_\_\_

( ) SINGLE ( ) MARRIED ( ) DOMESTIC PARTNER ( ) SEPARATED

( ) DIVORCED ( ) OTHER

### **EMPLOYER INFORMATION**

EMPLOYER NAME: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

ZIP: \_\_\_\_\_

### **PRIMARY INSURANCE**

INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

**POLICY HOLDER:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**Policy#:** \_\_\_\_\_

RELATIONSHIP TO INSURED: ( ) SELF ( ) SPOUSE ( ) CHILD ( ) OTHER

**SECONDARY INSURANCE**

INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_ POLICY HOLDER: \_\_\_\_\_ D.O.B \_\_\_\_\_

POLICY #: \_\_\_\_\_

RELATIONSHIP TO INSURED:      ( ) SELF    ( ) SPOUSE    ( ) CHILD    ( ) OTHER

**Release of Information**

I hereby authorize Open MRI of SANPC to release any information concerning my treatment to any insurance company for the purpose of determining eligibility for payment of insurance benefits. This included information regarding treatment for substance abuse or HIV.

I authorize Open MRI of SANPC to disclose protected health information (PHI) about me to the following person/people:

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Relation: \_\_\_\_\_ Relation \_\_\_\_\_

This authorization will permit Open MRI of SANPC to release any and all information pertaining to my health and well-being. **This authorization will expire on**

: \_\_\_\_\_.

(There must be a date of expiration/event, whether it is 10-100 years, divorce, death, etc.)

I understand that when my PHI is used or disclosed pursuant to this authorization, it may be subject to disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to: Open MRI of SANPC, 1040 Eagles Landing Parkway, Ste 102, Stockbridge, GA 30281.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date