Piedmont Physicians Welcomes

Kwon Choe, M.D.  Heath Hampton, M.D.  Kevin Lanclos, M.D.  Timothy Park, M.D.  Henry Patton, M.D.

Piedmont Physicians is excited to announce that Drs. Choe, Hampton, Lanclos, Park and Patton will be located at our new primary care offices in Social Circle and Conyers.

Piedmont Physicians of Social Circle
Internal Medicine
551 N. Cherokee Road
Social Circle, Georgia 30025
piedmont.org/SocialCircle

Piedmont Physicians of Conyers
Internal Medicine
1910 Highway 20 SE • Suite 270
Conyers, Georgia 30013
piedmont.org/Conyers

For more information or to schedule an appointment, call 678.342.6000.
PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) ___________________________ Nickname ___________________________ Sex:  □ Male  □ Female

Date of birth ___________________________ Social security number ___________________________ Race ___________________________ Preferred language ___________________________

Ethnicity:  □ Hispanic  □ Non-Hispanic  Marital status:  □ Single  □ Married  □ Separated  □ Divorced  □ Widowed  □ Life partner

Complete mailing address: ___________________________ (Street, city, state, zip code, county)

Home phone number: ___________________________ Cell phone number: ___________________________ Work number: ___________________________

Email: ___________________________

Employment status:  □ Full-time  □ Part-time  □ Active duty  □ Self-employed  □ Not employed  □ Retirement date: ___________________________

Employer name: ___________________________ Employer phone number: ___________________________

Employer complete address: ___________________________ (Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party)  □ Same as patient

Full legal name (First, Middle, Last, suffix) ___________________________ Date of birth ___________________________ Social security number ___________________________

Relation to patient:  □ Self  □ Spouse  □ Mother  □ Father  □ Legal guardian  □ Other: ___________________________ Sex:  □ Male  □ Female

Home phone number: ___________________________ Cell phone number: ___________________________ Work number: ___________________________

Complete mailing address – if different from patient: ___________________________ (Street, city, state, zip code, county)

Employment status:  □ Full-time  □ Part-time  □ Active duty  □ Self-employed  □ Not employed  □ Retirement date: ___________________________

Employer name: ___________________________ Employer phone number: ___________________________

Employer complete address: ___________________________ (Street, city, state, zip code)

EMERGENCY CONTACT INFORMATION

Name (First, Last): ___________________________

Relation to patient:  □ Spouse  □ Mother  □ Father  □ Legal guardian  □ Other: ___________________________

Home phone number: ___________________________ Cell phone number: ___________________________ Work number: ___________________________

Complete mailing address – if different from patient: ___________________________

INSURANCE INFORMATION  □ Self-pay (no insurance)

Primary insurance: ___________________________ Patient relation to subscriber:  □ Self  □ Spouse  □ Child  □ Other: ___________________________

Secondary insurance: ___________________________ Patient relation to subscriber:  □ Self  □ Spouse  □ Child  □ Other: ___________________________

Prescription/Rx provider: ___________________________ (if different from insurance carrier)

Full name of subscriber: ___________________________ (complete below if different from patient, spouse or guarantor)

Subscriber date of birth: ___________________________

Employment status:  □ Full-time  □ Part-time  □ Active duty  □ Self-employed  □ Not employed  □ Retirement date: ___________________________

Employer name: ___________________________ Employer size:  □ 0 – 19 employees  □ 20 – 99  □ 100+

Employer complete address: ___________________________ (Street, city, state, zip code)

Primary care physician: ___________________________

Do you want anyone to know you are here?  □ Yes  or  □ No

Not a Part of the Legal Medical Record
Authorization For Use/Disclosure of Protected Health Information

**PATIENT INFORMATION**

* The following information is needed to assist the provider in locating the patient’s records:

<table>
<thead>
<tr>
<th>Patient full name:</th>
<th>Date of birth:</th>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Maiden/other name:</th>
<th>Current address:</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Patient phone # (home):</th>
<th>(work):</th>
<th>(cell):</th>
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</table>

**REQUEST AUTHORIZATION**

I hereby request and authorize Health Information Management at (choose all applicable):

- [ ] Piedmont Atlanta Hospital
- [ ] Piedmont Fayette Hospital
- [ ] Piedmont Heart Institute
- [ ] Piedmont Henry Hospital
- [ ] Piedmont Medical Care Corporation
- [ ] Piedmont Mountainside Hospital
- [ ] Piedmont Newnan Hospital
- [ ] Piedmont Newton Hospital
- [ ] Other Emory at Covington –Newton Drive/Adams Street

To provide copies of my records checked below to:

<table>
<thead>
<tr>
<th>Name (receiving person/party):</th>
<th>Address:</th>
<th>Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPG - Social Circle</td>
<td>PO Box 1288, Social Circle, GA 30025</td>
<td>678-342-6000</td>
</tr>
</tbody>
</table>

Fax #: 678-342-6006 (required to verify Fax #)

To permit review of my records checked below by (person’s name):

To use/disclose PHI as described:

This authorization applies to records or PHI access from the following date or dates of service: **January 1, 2014 to Present**

**PURPOSE OF DISCLOSURE**

- [ ] At the request of the individual (patient)
- [ ] For a marketing function for which a Piedmont Provider receives direct or indirect remuneration from a third party.
- [ ] Other: Ongoing Patient Care

**DESCRIPTION OF INFORMATION TO BE RELEASED**

The information used/disclosed pursuant to this Authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

- [ ] Entire Medical Record
- [ ] Emergency Room Report
- [ ] Cardiac Cath Report/CD
- [ ] Pathology Slides/Blocks
- [ ] Financial Record
- [ ] Abstract of Record*
- [ ] Radiology Films/CD
- [ ] Other – Specify:

*An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

**AUTHORIZED SIGNATURES**

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization. A revocation form may be obtained from Health Information Management. The completed revocation must be presented to Health Information Management. I further understand that this Authorization is specific to the information checked above, for the date(s) of services indicated, and for the purpose written above. Piedmont Providers shall not condition treatment on the receipt of this Authorization, except when such conditioning is permitted for research-related treatment or in instances where the sole purpose of creating the health information is for disclosure to a third party (for example, fitness-for-duty exams).

I further understand that this Authorization is **valid for a period of 90 days** from today’s date and **will expire at that time unless another date is written here**:

**SIGN HERE**

Patient or Legal Representative signature

Please PRINT name

Today’s date

Time

As Legal Representative, my relationship to the patient is: _____________________________. Any document proving such authority must be attached.

The patient is unable to sign because: _____________________________.

**NOTE:** There may be fees for provision of any or all requested information. Under most circumstances, the law permits up to 30 days for record requests to be processed, however records for treatment purposes can be immediately faxed to the patient’s healthcare provider when requested.

Please mail to: Medical Records Request

1550 Litton Drive

Stone Mountain, GA 30083

Or fax to: 404.778.5028

35256P Rev. 10/16