

THE WOMEN'S CENTER PATIENT HISTORY

Have you had a mammogram before? No Yes - If so, where? _____ When _____
 Are you pregnant? No Yes Have you nursed (breastfed) in the past 6 months? No Yes
 Are you allergic to latex? No Yes Do you have breast implants? No Yes
 Have you lost or gained weight since your last mammogram? No Yes - if yes, _____ lbs lost/gained

Reason for Appointment:

Annual/ Routine Generalized Pain 6 month Follow Up Ultrasound
 Lump Focal Pain Call-Back/Add'l Views Film Consult
 Nipple Retraction/ Inverted Nipples Nipple Discharge – If yes, what color? _____

PERSONAL HISTORY

Have you ever had a needle biopsy, breast reduction, or any other breast surgery? No Yes

Technologist notes: _____

Do you have a personal history of breast cancer? No Yes
 If so when? _____ Which side? _____

Have you received: Radiation Therapy? No Yes Tamoxifen? No Yes
 Chemotherapy? No Yes Arimidex? No Yes

Or other medications related to breast cancer? _____

Do you have a history of any other cancer (especially Ovarian Cancer or Hodgkins Lymphoma)? No Yes
 If so, what? _____

FAMILY HISTORY

Is there a history of breast cancer in your family? No Yes
 Mother At what age? _____ Sister At what age? _____ Other _____ At what age? _____

Your age at the time of your first menstrual cycle? _____ Date of last menstrual cycle? _____

Are you on hormone replacement? No Oral Cream Patch

Age at onset of menopause? _____

Your age at the time of your 1st full term pregnancy? _____

Patient Signature: _____ **Phone #** _____

Technologist Notes: _____

Technologist: _____ Date: _____ Time: _____

MERIDIAN HEALTH
AUTHORIZATION FOR RELEASE OF INFORMATION
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Patient Name _____
Address (number and street) _____
City, State, Zip Code _____ Telephone _____
Date of Birth _____ Medical Record # _____

I hereby authorize and request Meridian Health to release information related to treatment at:
 Bayshore Community Hospital Jersey Shore University Medical Center Ocean Medical Center Riverview Medical Center
 Southern Ocean Medical Center Meridian Health Partner Other Meridian Facility (specify) _____

I authorize Meridian Health to obtain records from: _____
(Name of facility / provider and address)

The Purpose of the Release _____
Disclose Information to: _____
Name/ Facility _____
Address _____
City, State, Zip _____
Telephone# _____ Fax number _____

Information to be Released/Obtained
(Please check appropriate areas) and Type of Visit and Specify Treatment Date(s)
 Inpatient, Admission Dates _____
 Emergency Dept (not admitted) Date(s) _____
 Same Day/Outpatient Procedure Date(s) _____
 Outpatient (specify departments in which seen) _____ Clinic _____ Cardiovascular Phys. Therapy
 Speech & Hearing _____ Other (specify) _____
(specify dept. and dates)

Specified Reports:
 Abstract (Face Sheet, Discharge Summary, H&P, ED, Consults, OP Report, Pathology, Lab and Diagnostic Studies)
 Admission/Face Sheet Doctor's Orders Medication Sheets Radiology Films
 Cardiology Report Emergency Dept Mental Health Consults/Evaluations Radiology Report
 Complete Medical Record History and Physical Nurses Notes Radiation Therapy
 Consultation Report Immunization Record Operative Report EEG
 Discharge Summary Interdisciplinary Notes Pathology Report _____
 Doctor's Notes Laboratory Report Pathology Slides/Specimens _____

*Complete record includes: all patient information listed under Specific Reports.
I specifically authorize the use and/or disclosure of the following type of highly confidential information indicated by my initials next to the information type

I understand that this will include information relating to (check if applicable):
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
_____ Psychiatric Care _____ Genetic Information _____ Communicable Disease(s)
_____ Treatment for alcohol and/or drug abuse _____ Sexually Transmitted Disease(s)

I authorize the above person/organization and /or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information herein requested.

I understand that I may revoke this authorization to release information in writing at any time, except to the extent that action has been taken in reliance thereon. I understand that this authorization will expire on _____ (Insert date or event). **If I fail to specify an expiration date, event or condition, this authorization will expire in six months.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Legal Representative _____ Date _____ Time AM/PM _____
If signed by Legally Authorized Representative, Relationship to Patient _____ Signature of Witness _____ Date _____ Time AM/PM _____

NOTICE TO RECIPIENT OF INFORMATION
PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.



RI0000

AUTHORIZATION FOR RELEASE OF INFORMATION

ALL REQUESTS WILL BE PROCESSED IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS

Copies will be provided within thirty days of a proper written request.

FEE SCHEDULE:

- \$1.00 per page for first 100 pages
- \$0.25 a page for remaining pages but not to exceed \$200.00 per admission
- Plus postage

FEE SCHEDULE ABOVE IS NOT APPLICABLE FOR THE FOLLOWING:

- 1. Records mailed directly to a Physician/Health Care Facility**
The facility will mail copies of requested records directly to a Physician/Health Care Facility at no charge to the patient.
- 2. Defendant's attorney and Third Party Requestors not representing the patient.**
For information on the applicable fee schedule contact the Health Information Department -Release of Information.
- 3. Records in other than paper media.**
Please see/contact the Health Information Department or Radiology Department as appropriate.
_____ By initialing I acknowledge that I have read the above Fee Schedule.

Receipt of specimen (if applicable)
NOTE: Certain substances relating to this specimen may be considered carcinogenic, biohazardous, toxic or irritant material. Biohazardous is identified as material that may contain blood-borne pathogens that are potentially infectious.
I have read this warning label on the specimen and I am aware of the risk in exposure to these substances.

Signature of Person Receiving Sample _____ Date: _____ Time: _____ am/pm

For MH Department Use Only:

If the patient is a minor, a parent, next of kin or legal guardian must sign the authorization, with the following exceptions and as prohibited by law:

- The minor is pregnant. • The minor is married. • The minor is emancipated (court determined)
- The treatment is a state funded mental health service. • The treatment is for Drug and/or Alcohol Abuse.
- The treatment is for a Sexually Transmitted Disease. • The treatment is for AIDS or HIV.

If patient is deceased, proof of executor or administrator of estate is required, if not applicable surrogate certificate.

IDENTIFICATION VERIFIED VIA:
 DRIVER'S LICENSE GOVERNMENT ISSUED ID Verified By: _____

IF COPIES ARE HANDCARRIED, OBTAIN SIGNATURE BELOW:

Signature: _____ Date: _____ Time: _____ am/pm