PUTNAM SURGICAL GROUP
NORTH FLORIDA REGIONAL HEALTHCARE

PLEASE PRINT CLEARLY DATE _____

WHO IS YOUR PRIMARY DOCTOR? _____

PATIENT NAME_____ SS# _____

DOB_____/_____/_____ AGE_____ SEX_____ EMAIL_____

PHONE (_____)_____CELL PHONE (_____)_____

LOCAL ADDRESS_____ CITY_____ STATE FL ZIP_____

MARITAL STATUS: ____MARRIED ____SINGLE ____OTHER

RACE _____ ETHNICITY: _____HISPANIC OR LATIN_____NOT HISPANIC OR LATIN

EMPLOYED (PLEASE LIST EMPLOYER)_____ PHONE # (_____) _____

IF UNDER 18, MOTHER'S NAME_____SSN_____DOB_____PHONE(____)_____

IF UNDER 18, FATHER'S NAME_____SSN_____DOB_____PHONE(_____)_____

NAME OF SCHOOL_____ _____FULL-TIME STUDENT _____PART-TIME STUDENT

SPOUSE'S NAME_____PLACE OF EMPLOYMENT _____

WHERE AND WHEN HAVE YOU LIVED AND TRAVELED OUTSIDE THE U.S. AND CANADA? _____

PHARMACY _____

INSURANCE NAME_____

POLICY NUMBER_____GROUP NUMBER_____

INSURED'S NAME _____INSURED'S COMPANY_____

ADDRESS ON INSURANCE CARD_____

PHONE NUMBER FOR ELIGIBILITY ON BACK OF INSURANCE CARD_____

DO YOU HAVE A LIVING WILL / ADVANCED DIRECTIVE
(Circle One)
YES NO

In case of emergency please notify (Someone who does not live in your home) Relationship _____

Name_____ PHONE _____

ADDRESS _____

Patient General Consent to Treat

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing *(see revocation section below.)*

I understand that **Putnam Surgical Group, LLC (Putnam GI Associates, Putnam Orthopaedic Associates, and Putnam Surgical Associates)** may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

_____ _____

Patient (or responsible party) Signature Date

Revocation

_____*I hereby revoke my general consent to treat at Putnam GI Associates*

_____ _____

Revocation Signature (or representative) *Date*

Putnam Surgical Group, LLC

Putnam GI Associates / Putnam Orthopaedic Associates / Putnam Surgical Associates

Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations			
Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**	
Provider's Name:	**Recipient's Name:**		
Provider's Address: **Putnam GI Associates** **700 Zeagler Drive, Suite 8** **Palatka, FL 32177** **P: 386-328-4242 / F: 386-328-4244**	**Address 1:**		
	Address 2:		
	City:	**State:**	**Zip:**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative Information		☐ Labor/delivery sum.	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing Information		☐ UB-92:	
☐ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**