Caswell County Health Department
Yanceyville, NC 27379

PERMISSION TO USE AND DISCLOSE PATIENT HEALTH INFORMATION AND AND ASSIGNMENT OF BENEFITS

Last Name	First Name	MI

Patient SS#	Patient Date of Birth

Acknowledgement Of Receipt of The Notice Of Privacy Practices

I hereby acknowledge that I have received a copy of the "Notice of Privacy Practices" for the Caswell County Health Department and I understand that I may contact the person named herein if I have questions about the content of the notice.

Patient/Parent/Guardian	Date
Witness	Date

Consent For Use And Disclosure Of Health/Medical Information

I give my voluntary consent for the Caswell County Health Department to use and disclose health/medical Information regarding _____ for purposes of treatment, payment and healthcare operations as defined in the "Notice of Privacy Practices" mentioned above. I understand that the health/medical information used and disclosed may include information about communicable diseases (such as HIV). I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. I understand that this consent is valid until I revoke it and that if I want to revoke this consent, I must do so in writing.

Patient/Parent/Legal Guardian	Date
Witness	Date

Assignment of Benefits

I authorize all public and/or private health insurance to pay medical benefits directly to the Caswell County Health Department for services provided by the Caswell County Health Department, unless such payment is prohibited by the health provider. I understand that this consent is valid until I revoke it and that if I want to revoke this consent, I must do so in writing.

Patient/Parent/Legal Guardian	Date
Witness	Date

Caswell County Health Department, PO Box 1238, 189 County Park Rd, Yanceyville NC 27379

PATIENT AUTORIZATION TO PERMIT USE AND DISCLOSURE OF HEALTH INFORMATION

This form implements the requirements for patients authorization to use and disclose health information protected by the privacy law, a health care provider law, 45 C.F.R. parts 160, 164.Except as otherwise permitted or required by the privacy law, a health care provider subject to the privacy law may not use or disclose protected information without and authorization that complies with the requirements of 45 CFR 164.508©

Patient Name_____
SS Number_____
Date of Birth_____

I am either the patient named above or the patient's legally authorized representative. By signing the form, I authorize _____

To use or disclose to_____

The following protected health information: _____

The purpose of the use or disclosure is: _____

I understand the, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this authorization, I must do so in writing. The procedure for how I may revoke the authorization. As well as the exceptions to my right to revoke, are explained in Caswell County Health Department's Notice of Privacy, a copy of which has been provided to me.

I understand that I may refuse to sign this Authorization. I also understand that Caswell County Health Department cannot deny or refuse to provide treatment, Payment, enrollment in a health plan, or eligibility for benefits if I refuse to sign this authorization.

I understand that, once information is disclosed pursuant to the authorization, it is possible that it will no longer be protected by the federal medical privacy law and could be re-disclosed by the person or agency that receives it. I understand that my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it. **Notice to accompany release of confidential information consent form. Each disclosure made with the patient's written consent must be accompanied by the following written statement: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person 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.**This authorization expires automatically upon the following date or even that relates to the patient or the purpose of the use or disclosure_____

Signature of Patient:	
Please Print Name	**Date:**

OR

Signature of Authorized Representative:	
Please Print Name:	**Date:**
Please explain Representative's authority to act on behalf of patient:	

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.LP.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Caswell County Health Department to release my records and any information requested to the following individuals.

1. _____ **Relationship to Patient:**_____
2. _____ **Relationship to Patient:**_____
3. _____ **Relationship to Patient:**_____
4. _____ **Relationship to Patient:**_____

Authorization Regarding Messages
(please check all that apply)

____I authorize you to leave a detailed message on my home or cell number regarding appointments

____I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____I authorize you to leave a message with anyone who answers the phone

____Messages may only be left with _____

_____

Patient Name (PLEASE PRINT)_____ Date

Patient Signature _____

Caswell County Health Department
Patient Information Sheet

Name: _____ **Maiden Name/ Mother's Maiden Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Race: __White __African American/ Black __American Indian __Asian __Hawaiian/Pacific Islander
Hispanic/Latino Origin: __Yes __No **Country of Origin:** _____
Language Preferred: __ English __Spanish **Interpreter Needed:** __Yes __ No
Gender at Birth: __ Male __Female **Marital Status:** __Single __Married __Divorced __Widowed

Physical Address: _____
Mailing Address (If different) _____
Phone Number: Home_____ Work _____ Cell _____
Emergency Contact: Name_____ **Phone Number:** _____

Please complete the following information to determine if you are eligible for a discount based on your income and family size. This information is required for the discount/sliding scale.
***** You will be required to show proof of all income. *****

How many adults (over 21) in your household _____ How many children _____
Household Members Information:

Name	Relationship to patient	Age
	SELF	

List Employer/Income Source	Length of employment	Total Income before Taxes

Insurance: ____Yes ___No
Insurance Name _____
Group/Member ID Number _____

The information I have given above is correct. I understand the Health Department has the right to verify this information for accuracy.

Signature_____ **Date** _____

Caswell County Health Department
189 County Park Road; PO Box 1238
Yanceyville, NC 27379
P: 336-694-4129 F:336-694-7030

Parental Consent for non-custodial Parent/Guardian

I _____ being the legal custodial Parent/ Guardian

(Custodial Parent/Guardian)

of _____ give permission for the following person/people to

(Child's Name)

consent for medical treatment of my child.

_____ _____

_____ _____

This includes but is not limited to Emergency Medical Treatment, Doctor Appointments, Discussion of History and other personal information that has any effect on the medical treatment plan or diagnosis.

Effective Date (from)_____ (to)_____

Child's Date of Birth_____

Allergies, Surgeries or other Important Medical information needed for treatment_____

_____.

Signature_____

Date_____

NC Child Health Program Initial History Questionnaire *(created 7/1/2012)*

Patient Name:	Date of Birth:	Sex: (Circle) Male Female
Person Who Filled Out Form: Date Filled Out:	Relationship to Patient:	

PREGNANCY AND BIRTH HISTORY

Is the child adopted? No Yes
Birth Weight: _____ pounds _____ ounces
Was baby born on time? No Yes _____ weeks
Was the birth Vaginal C-Section If C-Section, Why?_____
_____
Were there any problems during the pregnancy or at birth?
No Yes If yes, explain: _____
_____
During pregnancy did mom:
Use tobacco? No Yes Drink alcohol? No Yes
Use drugs or other medications? No Yes What: _____
Use prenatal vitamins? No Yes When:_____
Did baby have problems or need to stay in a NICU?
No Yes If yes, explain: _____
The initial feeding for the baby was: Formula Breast milk
How long did the baby breastfeed? _____
Did the baby go home with mom? No Yes
If no, explain: _____

HOUSEHOLD

List names, relationships to child, and ages of all people living with the child:
_____
_____
_____
Are there siblings not listed? If so, list names, ages and where they live:
_____
_____
What is your child's living situation?

Joint custody Single custody Foster care

If one or both parents are not living in the home, how often does the child see the parent not in the home?
_____
Tobacco use in family? No Yes Who?: _____

CHILD'S HEALTH HISTORY

Has the child ever had:

Hospitalizations	No	Yes
Serious Injuries/Broken Bones	No	Yes
Surgeries	No	Yes
Allergies To Medications/Other:		
_____	No	Yes
Chicken Pox (Year) _____	No	Yes
Frequent Ear Infections	No	Yes
Vision/Hearing Problems	No	Yes
Nasal Allergies	No	Yes
Asthma /Lung Problems	No	Yes
Tuberculosis(TB)/Risks for TB	No	Yes
Any Heart Problems/Murmur	No	Yes
Anemia/Sickle Cell	No	Yes
Bleeding Problems/Transfusion	No	Yes
Immune Problems/HIV	No	Yes
Cancer	No	Yes
Stomach Aches/Constipation	No	Yes
Bladder Infections/Kidney Disease	No	Yes
Birth Defects	No	Yes
Metabolic/Genetic Conditions	No	Yes
Sleep/Snoring/Bed Wetting Issues	No	Yes
Chronic Skin Problems/Eczema	No	Yes
Frequent Headaches	No	Yes
Seizures/Neurological Problems	No	Yes
Obesity	No	Yes
Diabetes	No	Yes
Thyroid/Endocrine Problems	No	Yes
High Blood Pressure	No	Yes
Alcohol/Drug Use/Tobacco	No	Yes
ADHD/Anxiety/Mood/Depression	No	Yes
Developmental Delay/Disability	No	Yes
Dental Decay/Cavities	No	Yes
History of Family Violence/Abuse	No	Yes
Sexual Infections/Pregnancy	No	Yes
Elevated Lead Level	No	Yes
Other: _____	No	Yes

BIOLOGICAL FAMILY HEALTH HISTORY

Has anyone in the family of the child (parents, grandparents, sisters/brothers) had:

			Who?
Childhood Hearing Loss	No	Yes	_____
Nasal Allergies	No	Yes	_____
Asthma	No	Yes	_____
Tuberculosis (TB)/Risks for Tuberculosis	No	Yes	_____
Lung Problems	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure/Stroke	No	Yes	_____
High Cholesterol/Takes Cholesterol Medication	No	Yes	_____
Anemia/Sickle Cell	No	Yes	_____
Bleeding Problems	No	Yes	_____
Dental Decay (cavities)	No	Yes	_____
Cancer	No	Yes	_____
Liver Disease/Hepatitis	No	Yes	_____
Kidney Disease	No	Yes	_____
Diabetes (high blood sugar)	No	Yes	_____
Obesity	No	Yes	_____
Seizures/Epilepsy	No	Yes	_____
Alcohol Abuse	No	Yes	_____
Drug Abuse	No	Yes	_____
Mental Illness/Depression	No	Yes	_____
Development Delay/Disability	No	Yes	_____
Immune Problems/HIV/AIDS	No	Yes	_____
Other Family History:			
_____	No	Yes	_____

Additional Comments:

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North Carolina Department of Health and Human Services
Division of Public Health
Reproductive Health Section

Place Patient Label Here

BIOLOGICAL MALE REPRODUCTIVE HEALTH HISTORY

Date: _____

A. GENERAL INFORMATION

1. May we contact you by mail? ☐ Yes ☐ No By phone? ☐ Yes ☐ No Your phone number is _____
2. Do you have a primary care provider? ☐ Yes ☐ No If yes, who? _____
   If No a referral to a primary care provider is offered ☐ Yes ☐ No
3. Hearing, visual, language and/or physical accommodation needs/Primary Language(s) _____
4. Highest grade completed in school _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you currently take any medications (prescription or over the counter), diet or herbal supplements? ☐ Yes ☐ No If yes, what? _____
3. Self and Family Medical History: Put an X under **SELF** and/or X under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
☐	☐	1. Heart disease/vascular problems (blood clots)	☐	☐	7. Liver Disease
☐	☐	2. Sickle Cell Disease or Trait/Blood Disorder	☐	☐	8. Migraine Headache (with aura)
☐	☐	3. Diabetes	☐	☐	9. Cancer
☐	☐	4. High Blood Pressure /High cholesterol	☐	☐	10. Mental Illness/Emotional Disorders
☐	☐	5. Lung Disease	☐	☐	11. Other
☐	☐	6. Infertility			

If yes to any of the above, please explain:

C. SOCIAL/ENVIRONMENTAL HISTORY

1. Do you currently use tobacco, including cigarettes, smokeless tobacco, electronic devices, or other products?
   ☐ Yes ☐ No If yes, what type?_____How long?_____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much?_____How long?_____
3. Use recreational drugs? ☐ Yes ☐ No If yes, what type?_____How often?_____
4. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or recreational drugs?
   ☐ Yes ☐ No If yes, what do they use?_____How often?_____

D. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

Interviewer's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____

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North Carolina Department of Health and Human Services
Division of Public Health
Reproductive Health Branch

Place Patient Label Here

BIOLOGICAL **FEMALE REPRODUCTIVE HEALTH HISTORY**

Date: _____

A. GENERAL INFORMATION

1. May we contact you by mail? ☐ Yes ☐ No By phone? ☐ Yes ☐ No Your phone number is _____
2. Do you have a primary care provider? ☐ Yes ☐ No If yes, who? _____
   If No a referral to a primary care provider is offered ☐ Yes ☐ No
3. Hearing, Visual, Language and/or Physical Accommodation needs/Primary Language(s) _____
4. Highest grade completed in school _____

B. MEDICAL HISTORY, HOSPITALIZATIONS, MEDICATIONS

1. List hospitalizations, surgeries and dates: _____
2. Medications: Do you take a multivitamin and/or a folic acid? ☐ Yes ☐ No Do you currently take any medications (prescription or over the counter), diet or herbal supplements? ☐ Yes ☐ No If yes, what? _____
3. Self and Family Medical History: Put an **X** under **SELF** and/or **X** under **FAMILY** (parent, grandparent, brother, sister or your child)

SELF	FAMILY		SELF	FAMILY	
☐	☐	1. Heart disease/vascular problems (heart attack, blood clots, stroke)	☐	☐	6. Liver Disease
☐	☐	2. Sickle Cell Disease or Trait/Blood Disorder	☐	☐	7. Migraine Headache (with aura)
☐	☐	3. Diabetes/Gestational Diabetes (if postpartum and had GDM, then repeat screening)	☐	☐	8. Cancer
☐	☐	4. High Blood Pressure /High cholesterol	☐	☐	9. Mental Illness/Emotional Disorders
☐	☐	5. Lung Disease	☐	☐	10. Other
If yes to any of the above, please explain:					

C. GYNECOLOGICAL HISTORY

1. Menstrual history: At what age did you have your first period?_____How often do you have your period? _____
   How many days does your bleeding last? _____Do you have any concerns about your periods? _____
2. Any history of gynecologic conditions such as endometriosis, fibroids, ovarian cysts, chronic pelvic pain polycystic ovarian syndrome, infertility, etc.? _____
3. Breast problems such as cysts, tumors, discharge, biopsies or surgeries? _____
4. Date of last Mammogram_____
5. Date of last Pap test _____History of any abnormal Pap tests? ☐ Yes ☐ No If yes, in what year, what results, and what was done? _____
6. **Past birth control methods used:** ☐ OCP (type)_____ ☐ Depo ☐ Condoms ☐ BTL ☐ Patch ☐ Ring ☐ Implant ☐ IUD ☐ FABM ☐ Other ☐ None

Concerns or problems with past methods? _____

D. Obstetrical History

1. Gravida _____ # Carried to term _____ # Preterm _____ #Abortion/Miscarriage <20 weeks _____ #Living _____

E. SOCIAL/ENVIRONMENTAL HISTORY

1. Do you currently use tobacco, including cigarettes, smokeless tobacco, electronic devices, or other products?
   ☐ Yes ☐ No If yes, what type?_____How long?_____
2. Drink alcohol? ☐ Yes ☐ No If yes, how much?_____How long?_____
3. Use recreational drugs? ☐ Yes ☐ No If yes, what type?_____How often?_____

4. Are you regularly around someone else who uses alcohol, tobacco, electronic nicotine devices or recreational drugs?
   ☐ Yes ☐ No If yes, what do they use?_____How often?_____

F. IMMUNIZATION ASSESSMENT PER CDC ACIP GUIDELINES (UTD = up-to-date; REF = referred, and NA = not applicable)

Td/Tdap ☐ UTD ☐ REF ☐ NA	MMR ☐ UTD ☐ REF ☐ NA	Varicella ☐ UTD ☐ REF ☐ NA	HPV ☐ UTD ☐ REF ☐ NA	Hepatitis A ☐ UTD ☐ REF ☐ NA
Hepatitis B ☐ UTD ☐ REF ☐ NA	Meningococcal ☐ UTD ☐ REF ☐ NA	Pneumonia ☐ UTD ☐ REF ☐ NA	Influenza ☐ UTD ☐ REF ☐ NA	

Source of Information: ☐ NCIR ☐ Patient ☐ Other Written Documentation

Interviewer's Signature: _____ Date: _____

Signature of Interpreter (if used): _____ Date: _____