LILLETTE A. INTAPHAN MD, LLC
657 HEMLOCK STREET, SUITE # 221
MACON, GEORGIA 31201
(478) 750-8984 FAX: (478)746-1530

DATE:_____

NAME:_____ DATE OF BIRTH:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____
PHONE #:_____ CELL #:_____
SSN:_____ RACE:_____LANGUAGE:_____
___ SINGLE ___MARRIED ___ DIVORCED ___WIDOWED
NAME OF SPOUSE:_____

****

NAME OF EMPLOYER:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____
PHONE #:_____

****

NAME OF INSURANCE:_____
POLICY #:_____ GROUP #:_____

SECONDARY INSURANCE:_____
POLICY #:_____ GROUP #:_____

****

EMERGENCY CONTACT:_____RELATION:_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP CODE:_____
PHONE #:_____ CELL #:_____

****

NAME OF YOUR PHARMACY:_____ LOCATION:_____

WHO MAY WE THANK FOR REFERRING YOU?_____

DO YOU HAVE A LIVING WILL? ___YES ___NO

E-MAIL ADDRESS:_____

*PATIENT (GUARDIAN) SIGNATURE:_____

LILLETTE A. INTAPHAN, M.D.
Diplomate American Board of Internal Medicine

657 Hemlock Street • Suite 221 • Macon, Georgia 31201 • (478) 750-8984 • Fax (478) 746-1530

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPPA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by our staff in providing and arranging your medical care.

Permissions regarding the consent to disclose your protected health information for informative purposes and/ or treatment provided by ***Lillette A. Intaphan MD*** are granted on this form.

HIPPA Privacy Act Information Release Form

Please mark below for release of information concerning your healthcare:

Release Information ONLY to me (patient): Yes ☐ No ☐

Release of information to spouse: Yes ☐ No ☐
Name of spouse:_____

Release information to other individual(s): Yes ☐ No ☐

1. Name of individual: _____ Relationship: _____
2. Name of individual: _____ Relationship: _____
3. Name of individual: _____ Relationship: _____
4. Name of individual: _____ Relationship: _____

May our office leave detailed information on your answering machine(s)? Yes ☐ No ☐

May we send appointment reminders and messages via email? Yes ☐ No ☐

By signing this form, you acknowledge that you have provided ***Lillette A. Intaphan, MD, LLC*** with instructions regarding release of your individual healthcare information.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

FAMILY HISTORY

PATIENT NAME:_____DOB:_____

	MOTHER	FATHER	SIBBLING	SIBBLING	CHILD	CHILD
LIVING OR DECEACED?						
CURRENTAGE OR AGE OF DEATH						
DIABETES						
HIGH/ LOW BLOOD PRESSURE						
HEART DESEASE/ HEART ATTACK						
STROKE						
MENTAL ILLNESS						
CANCER						
UNKNOWN						

PERSONAL HISTORY:

HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES?

1. HEART DISEASE ____YES ____NO
2. RHEUMATOID ARTHRITIS ____YES ____NO
3. GONORRHEA OR SYPHALIS ____YES ____NO
4. GALLBLADDER DISEASE ____YES ____NO
5. ANEMIA ____YES ____NO
6. JAUNDICE ____YES ____NO
7. HEPATITIS ____YES ____NO
8. EPILEPSY ____YES ____NO
9. MIGRAINES ____YES ____NO
10. DIABETES ____YES ____NO
11. HIV ____YES ____NO
12. TUBERCULOSIS ____YES ____NO
13. CANCER ____YES ____NO
14. HIGH OR LOW BLOOD PRESSURE ____YES ____NO
15. BOWEL DISEASE ____YES ____NO
16. ASTHMA ____YES ____NO
17. FAINTING ____YES ____NO
18. VISION CHANNGES ____YES ____NO
19. HEARING PROBLEMS ____YES ____NO
20. CHEST PAIN ____YES ____NO
21. LUNG DISEASE ____YES ____NO
22. WEAKNESS/ NUMBNESS ____YES ____NO
23. MENSTRUAL PROBLEMS ____YES ____NO

DO YOU SMOKE? ____YES ____NO IF YES, HOW MUCH? _____

DO YOU DRINK ALCOHOL?____YES ____NO IF YES, HOW MUCH?_____

CURRENT MEDICATIONS:	SURGERIES:	HOSPITILIZATIONS:

CENTRAL GEORGIA HEALTH EXCHANGE

The next generation of patient information

Permission to Create a *Health Exchange record* and Share My Medical Information with my Healthcare Providers

We are taking part in an exciting program to improve your healthcare and make office visits easier and more convenient. To do this, all of your doctors participating in the Central Georgia Health Network (CGHN) would like your permission to share your Health Information (as defined below) through the *Central Georgia Health Exchange* electronic medical record program (*Health Exchange*). This will authorize your CGHN-participating doctors to disclose your Health Information so that it can be shared electronically with other providers of healthcare to you.

I acknowledge that I have read the information set forth below and understand the permission I am giving in this document, and have had the opportunity to have my questions answered about the *Health Exchange and this* permission form.

☐ **Yes, I agree to participate in the Central Georgia Health Exchange electronic medical record**

☐ **No, I do not wish to participate in the Central Georgia Health Exchange electronic medical record at this time**

_____	_____	_____
Printed Name of Patient/Representative	*Signature of Patient/Representative*	*Date*

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis:

Relationship to Patient: _____

[A signed copy of this permission will be provided to the patient/representative]

This authorization will allow your CGHN-participating doctors to disclose your demographic, insurance, and medical information so that it can be shared with other providers of healthcare to you (including doctors, nurses, and other health professionals, as well as hospitals and other healthcare facilities) and CGHN, through the *Health Exchange* electronic medical record system. Only authorized healthcare providers and their contractors, and others whose job it is to maintain, secure, monitor and evaluate the operation of the information system and quality of care, would be able to access your information. The *Health Exchange* will allow your providers access to your health information more quickly and accurately than with paper charts.

By signing this authorization, I authorize all of my doctors who participate in CGHN to use and disclose my Health Information and to make such Health Information available through the *Health Exchange* to other healthcare providers who need access to my Health Information for the purposes described in this document. The Health Information may include, but is not limited to the following: Information contained in medical records; physicians' records; surgeons' records; x-rays, CAT scans, MRI films, photographs, or other radiological, nuclear medicine or radiation therapy films; pathology materials, slides or tissues; laboratory reports; genetic testing results; discharge summaries; progress notes; consultations; prescriptions; records of child abuse, spousal abuse, drug abuse and alcohol abuse; HIV/AIDS and sexually transmitted diseases diagnosis or treatment; physicals and histories; nurses' notes; patient intake forms; correspondence; social workers' records; insurance records; consents for treatment; and any other documents concerning any treatment, examination, periods of hospitalization, confinement, diagnosis or other information concerning my physical or mental condition.

Information disclosed pursuant to this permission may no longer be protected by federal health information privacy laws and may be subject to re-disclosure. However, the *Health Exchange* system incorporates access controls, encryption technology and other security features designed to protect the privacy and security of your Health Information. In addition, access to the *Health Exchange* will be limited to only those users who have agreed to use the *Health Exchange* consistent with your permission. Information shared through the *Health Exchange* will be used and disclosed for the following purposes and disclosures: clinical care; obtaining reimbursement for health care services; for administrative functions related to the provision of and payment for care; quality monitoring and improvement; and administrative management of the *Health Exchange* and CGHN.

You can learn more about the *Central Georgia Health Exchange* by reading the information booklet, "A Guide to the Central Georgia Health Exchange" that is available at the CGHE website (https://www.CGHE.net) or on request from your healthcare provider's office.

I understand that I may withdraw this permission by giving written notice to Administrator, Central Georgia Health Exchange, 111 Perimeter Parkway Macon, GA 31210. Any withdrawal of permission will be effective except to the extent action already has been taken in reliance on this permission. This permission will expire automatically if the *Central Georgia Health Exchange* program is discontinued.

I understand that my eligibility for treatment or any healthcare benefits cannot be conditioned on whether I sign this permission. However, to the extent I have refused permission, I understand that my Health Information will not be available to my other healthcare providers (including, but not limited to, participating Emergency Rooms, Urgent Care Centers, Hospitals, Surgery Centers, and Doctors' Offices) through the *Central Georgia Health Exchange*.