Atlantic
Health System
Atlantic Medical Group

DT104

Date: _____

Patient Name: _____

# PATIENT DEMOGRAPHICS

| | | |
|---|---|---|
| **PATIENT INFORMATION:** | | |
| Last Name: | First Name: | Date of Birth: |
| Address: | City: | State: Zip: |
| Home Phone: | Cell Phone: | |
| E-Mail Address: | Sex: | Religion: |
| Employer: | Occupation: | Work Phone: |
| Primary Language: | Ethnic Origin: | Race: |
| **EMERGENCY CONTACT INFORMATION:** | | |
| Name: | Relationship: | Phone: |
| Can we leave a message on home/cell phone with test results? HOME: ☐YES ☐NO CELL: ☐YES ☐NO | | |
| Can we speak to a family member about your care and test results? ☐YES ☐NO | | |
| If yes, please list name(s): _____ | | |
| **PRIMARY INSURANCE:** | | |
| POLICY HOLDER: | | |
| Last Name: | First Name: | Date of Birth: |
| Address: | City: | State: Zip: |
| Relationship to Patient: | | |
| Employer: | Employer Phone Number: | |
| Address: | City: | State: Zip: |
| Insurance Name: | | |
| Address: | City: | State: Zip: |
| Insurance ID#: | Group #: | |
| **SECONDARY INSURANCE:** | | |
| POLICY HOLDER | | |
| Last Name: | First Name: | Date of Birth: |
| Address: | City: | State: Zip: |
| Relationship to Patient: | | |
| Employer: | Employer Phone Number: | |
| Address: | City: | State: Zip: |
| Insurance Name: | | |
| Address: | City: | State: Zip: |
| Insurance ID#: | Group #: | |



AH11324 (12/20)

Atlantic
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# PATIENT/FAMILY CONTACT LIST

Patient's Name: _____ DOB: _____

**Contacts**
People who have permission to receive detailed information about your care (PHI):

**PRIMARY CONTACT**

Name:
Relationship:
☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

**SECONDARY CONTACT(S)**

Name:
Relationship:
☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

Name:
Relationship:
☐ Check here if you would like us to involve this person in discussions about your health care

Phone Numbers
Cell: _____ _____ _____
Home: _____ _____ _____
Other: _____ _____ _____

☐ **I decline to designate a representative at this time.**

Comments/Other Information:

This form is effective upon execution and will remain in effect unless revoked by me.

Patient/Guardian Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____

# Advanced Care Oncology & Hematology Associates, LLC

Patient Name: _____

## Patient Social Secuity #

Social Security #: _____

## Pharmacy Information

Address: _____

Preferred Pharmacy Name: _____

Phone #: _____

## Pharmacy ID Card Info

Rx Bin: _____

Rx PCN: _____

Rx ID: _____

Rx Group # _____

Phone # _____

## Any known allergies?

If yes, please list: _____

Atlantic Health System

DT2201

# AUTHORIZATION FOR RELEASE OF INFORMATION

MRN/HAR: _____

Request ID: _____

**SECTION A:** **Patient Information:** Daytime Phone Number: _____

Patient Name: _____ Date of Birth: _____

Patient's Address: _____

**I hereby authorize and request Atlantic Health System to release information related to treatment at (check one):**

☐ Morristown Medical Center ☐ Overlook Medical Center ☐ Newton Medical Center ☐ Chilton Medical Center

☐ Hackettstown Medical Center ☐ Pharmacy ☐ Atlantic Medical Group (specify): _____

☐ Atlantic Visiting Nurse ☐ Other (specify): _____

**Information to be released to (receiver):** ☐ Check if the same as patient

Recipient Name/Facility/Organization: _____

Complete Address: _____

Phone Number: _____ Attention to: _____

**Purpose of Release:** ☐ Physician ☐ Facility ☐ Personal Use ☐ Legal ☐ Other: _____

**Request Delivery Type** *(if blank, a paper copy will be provided)*: ☐ Paper Copy ☐ Electronic Media (CD) ☐ MyChart

☐ Encrypted Email*: _____ ☐ Fax Number: _____ ☐ Pick-Up

In the event the facility is unable to accommodate an electronic delivery as requested, an alternate delivery will be provided (e.g. paper). ☐ Postal Mail

**NOTE: Choosing encrypted email delivery involves some level of risk. We are not responsible for unauthorized access to the PHI contained in this format, or any risks (e.g. virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.*

**SECTION B:** ☐ **I hereby authorize Atlantic Health System to obtain medical records from:**

Name: _____ Fax Number: _____

Address: _____ Dates of Service: _____

**SECTION C:** **Description of Information to be Released/Obtained:** **Dates of Service:** _____

☐ Abstract (most common) face sheet, discharge summary, history & physical, consult, test results, operative reports, ED

| | | | |
|---|---|---|---|
| ☐ Admission/Face Sheet | ☐ EEG/Sleep Reports | ☐ Mental Health Consult/Eval | ☐ _____ |
| ☐ Complete Medical Record | ☐ History & Physical | ☐ Operative Report | ☐ _____ |
| ☐ Consultation Report | ☐ Immunization Record | ☐ Pathology Report | ☐ _____ |
| ☐ Discharge Summary | ☐ Laboratory Report | ☐ Pathology Slides/Specimen | |
| ☐ Cardiology/Radiology Images | ☐ Medication Record | ☐ Radiology Report | |

Special Instructions: _____

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:

_____ HIV/AIDS Treatment Records _____ Psychiatric Treatment Records _____ Genetic Testing/Treatment Records

_____ Treatment for Alcohol and/or Drug Abuse _____ Sexually Transmitted Diseases Testing

**SECTION D:** **Patient Authorization: I understand that:**

1. Unless revoked by me, this authorization is valid for 6 months from the date above. Revocations must be made in writing. Mail revocation to any of our locations on the back of this form. Revocation may not be made if action has already been taken in reliance on this authorization.
2. I understand the terms of this authorization are governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, it may be amended from time to time.
3. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, insurance payment or eligibility benefits.
4. Atlantic Health System cannot guarantee that the recipient identified will not re-disclose my health information to a third party.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.

Patient/Authorized Representative or Guardian: _____ Date: _____ Time: _____

*(signature of minor at age or above 12 is required for certain information)*

If signed by legal authorized representative, specify relationship: _____

Atlantic Health System Personnel Signature: _____ Date: _____ Time: _____