WELCOME TO OUR PRACTICE

We are happy you have chosen MAHEC Internal Medicine for your care!

Our practice is designed to provide comprehensive care for adults including the diagnosis, treatment, and prevention of disease. We focus on delivering high quality and thoughtful medical care to patients from late adolescence through geriatrics. Our comprehensive approach provides care for short and long term (chronic) illnesses, acute issues, and age based preventive care.

Our top notch staff may call you to gather information before your visit. This allows our providers to focus more on your active problems at the visit. If our staff are unable to reach you before the appointment, we ask that you fill out the attached new patient history forms and bring them to your appointment. This will help us see you more efficiently on the day of your appointment.

OFFICE HOURS

Monday - Friday 8:00 am - 5:00 pm

If you are an established patient and have a true emergency after hours, please go to your nearest Emergency Department. You may also reach our after-hours service at 828-771-3500. Please note that we do not prescribe controlled substances on the first visit or after hours.

MAHEC Internal Medicine

Mary C. Nesbitt Biltmore Campus, 123 Hendersonville Road, Asheville, NC 28803

Phone: 828-771-3500 | **Fax:** 828-412-4171

Welcome to MAHEC!

Thank you for choosing us for your healthcare. MAHEC has been a part of Asheville since 1974 and we proudly continue our tradition of award-winning care. Our providers and staff welcome the opportunity to care for your entire family at our Family Health Centers, Internal Medicine office, OB/GYN offices, Dental offices and Center for Psychiatry. We proudly serve all patients regardless of income or insurance status.

- MAHEC is expanding our financial assistance program to go above and beyond what we have offered before. In order to facilitate this change we are asking all existing and new patients to complete a new patient information packet.
- Our Patient Financial Advocates are available to guide you through signing up for assistance offered through our Sliding Scale Discount Program. Eligibility is based on family income and family size. Payment is expected at time of service for amounts you are responsible for. We can assist with payment options if you are unable to pay in full.

BEFORE YOUR VISIT

This welcome packet includes forms you need to read and complete before your visit.

It is **VERY** important that you fill out each form completely and give the entire packet to the front desk staff when you arrive for your appointment. Please arrive **15 minutes before you appointment** to complete the check-in process.

Other documentation you need to bring with you:

- Insurance card and driver's license (or other valid photo ID)
- Pertinent medical history or records
- Current List of medications or medication bottles
    - Drug name
    - Prescribed dosage(s)
    - How long you have been taking the drug(s)

MAHEC's Patient Portal

We are pleased to provide all patients with an online tool that provides 24/7 access to your personal health record. With the portal, you can securely email your provider, see lab results, review your medical records and much more. We will use the email address you provide to give you access to the portal if you don't currently have it. Just watch for an email with instructions that will come to you after your appointment.

Thank you for choosing us for your healthcare!

Mountain Area Health Education Center
www.mahec.net

Name: _____

DOB: _____

MRN#: _____

Who may we speak with?

This form will allow MAHEC to **discuss** your medical and financial information about the care and services you have received with individuals of your choosing. This form does not allow the listed individuals to obtain copies of your medical or financial information. **You may list up to three (3) individuals below OR choose not to list anyone. You can update this form at any time.**

Person #1 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

Person #2 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

Person #3 that we can speak with

Name: _____

Relationship: _____ Phone #: _____

OR

☐ I do not wish to list anyone at this time.

_____ _____

Signature of patient, parent, or legal guardian Date

MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

☐ Psychiatry ☐ Internal Medicine ☐ FHC Biltmore ☐ FHC Cane Creek ☐ FHC Enka/Candler ☐ FHC Newbridge ☐ Ob/Gyn Biltmore
☐ Pharmacy at Enka ☐ Pharmacy at Biltmore ☐ Ob/Gyn Franklin ☐ Women's Care Brevard ☐ Deerfield ☐ Givens

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____ Birth Sex: ☐ Male ☐ Female

City: _____ State: _____ ZIP: _____ SS#: _____

Home County: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

By providing a phone number, mobile phone number, or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Special Hearing Needs:

_____

Special Vision Needs:

_____

Uses Wheelchair: ☐ Yes ☐ No

Speech Impaired: ☐ Yes ☐ No

Veteran Status: ☐ Yes ☐ No

Race (select all that apply):

Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian/Other Pacific Islander
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian/Chamorro
- ☐ Samoan

☐ Black/African American
☐ American Indian/Alaska Native
☐ White
☐ Choose not to disclose

Ethnicity (select all that apply):
- ☐ Mexican/Mexican American/Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Hispanic/Latino/Spanish
- ☐ Non-Hispanic/Latino/Spanish
- ☐ Choose not to disclose

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Something else: _____
- ☐ Choose not to disclose

Preferred Pronoun (She/Her, He/Him, They/Them etc.):

_____

Sexual Orientation:
- ☐ Lesbian or Gay
- ☐ Heterosexual (or straight)
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

Preferred Language:
- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ American Sign Language

Something else: _____

Marital Status:
- ☐ Single
- ☐ In a relationship
- ☐ Partner
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Special Populations

Migratory ☐ Yes ☐ No
Seasonal ☐ Yes ☐ No
Homeless ☐ Yes ☐ No

Homeless Status (select one):
- ☐ Not homeless
- ☐ Unhoused
- ☐ Transitional
- ☐ Doubling up
- ☐ Street
- ☐ Permanent supportive housing
- ☐ Something else: _____

EMERGENCY CONTACT INFORMATION

MRN #: _____

Name: _____

Relationship: _____ Phone#: _____

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: _____

Relationship: _____ Phone#: _____

ANNUAL HOUSEHOLD INCOME BEFORE TAXES

_____ # of Individuals in Household: _____

The income information above is used for statistical information only and is not used to determine specific patient financial needs.

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: ☐ Male ☐ Female

Policy Holder's Address: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy ID#: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Relationship to Patient: _____ Policy Holder's Birth Sex: ☐ Male ☐ Female

Policy Holder's Address: _____

ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to my insurance, Medicaid, and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand that MAHEC:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice.

I have read and understand the above.

Patient or Parent/Guardian Signature: _____ Date: _____

Note: Failure to sign does not relieve you of the above expectations.

MRN #: _____

CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services, and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me at any MAHEC facility. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound, and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient or Parent/Guardian Name (please PRINT): _____

Patient or Parent/Guardian Signature: _____ Date: _____

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC's Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment, MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) in accordance with MAHEC's Notice of Privacy Practices.

Patient or Parent/Guardian Signature: _____ Date: _____

FOR OFFICE USE ONLY

Primary Care Provider: _____

Copy of insurance card obtained? ☐ Yes ☐ No

MAHEC

New Patient Intake Form

☐ INTERNAL MEDICINE

Patient Name: _____ Date of Birth: _____

Form Completed by: _____ Date of Today's Visit: _____

Have you received medical care from another physician in the last 5 years? ☐ Yes ☐ No If yes, please give name and location.

Physician name: **Physician city and state:**

_____ _____

_____ _____

_____ _____

What is the reason for your visit today? _____

ALLERGIES

Do you have any allergies or bad reactions to medicines, foods or latex? ☐ Yes ☐ No If yes, please list them below.

Medicine, food, latex or other substance: **Reaction caused:**

_____ _____

_____ _____

MEDICATIONS

Please list ALL medications you currently take (including birth control pills, vitamins, supplements and herbs) even if you do not take them every day, and even if they are over the counter.

Name of medication, vitamin, herb or supplement:	Dosage (ex: how many mg or tablets you take)	How often you take it:

Local Pharmacy: _____ Mail Order: _____

MEDICAL HISTORY

Have you ever had any the following? Please check the boxes of all that apply to you.

- ☐ Alcohol abuse
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Attention Deficit Disorder
- ☐ Bipolar Disorder
- ☐ Bladder problems
- ☐ Blood clots
- ☐ Breast cancer, when: _____
- ☐ Colorectal cancer, when: _____
- ☐ Cancer, other: _____
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ GERD/Reflux
- ☐ Heart attack, when: _____
- ☐ Heart failure
- ☐ Hepatitis, choose: ☐ A ☐ B ☐ C
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ History of physical abuse
- ☐ History of sexual abuse
- ☐ Irritable Bowel Syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Skin cancer, when: _____
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Other:

_____

_____

_____

_____

_____

_____

_____

Patient Name: _____ Date of Birth: _____

SURGICAL HISTORY

What surgeries or procedures have you had? Please check the boxes of all that apply to you.

- ☐ Amputation, where: _____ Year: _____
- ☐ Appendix removed Year: _____
- ☐ Artificial joints, where: _____ Year: _____
- ☐ Back surgery Year: _____
- ☐ Breast surgery ☐ Left ☐ Right Year: _____
- ☐ Cataract extraction ☐ Left ☐ Right Year: _____
- ☐ Catheterization of heart Year: _____
- ☐ Gall bladder removed Year: _____
- ☐ Heart surgery Year: _____
- ☐ Hernia repair ☐ Left ☐ Right Year: _____
- ☐ Knee surgery ☐ Left ☐ Right Year: _____
- ☐ Neck surgery Year: _____
- ☐ Ovaries removed ☐ Left ☐ Right Year: _____
- ☐ Stress test of heart Year: _____
- ☐ Tonsils removed Year: _____
- ☐ Tubes tied Year: _____
- ☐ Uterus removed Year: _____
- ☐ Vasectomy Year: _____

Description of surgery or any other surgeries you have had: _____

_____

IMMUNIZATION HISTORY

Are your childhood vaccinations up to date? ☐ Yes ☐ No ☐ Unsure Have you had the following vaccines?

- Flu (this year) ☐ Yes ☐ No Date: _____
- Hepatitis B ☐ Yes ☐ No Date: _____
- Pneumonia (Prevnar) ☐ Yes ☐ No Date: _____
- Pneumonia (Pneumovax) ☐ Yes ☐ No Date: _____
- Pertussis ("whooping cough") ☐ Yes ☐ No Date: _____
- Shingles ☐ Yes ☐ No Date: _____
- Tetanus ☐ Yes ☐ No Date: _____
- COVID ☐ Yes ☐ No Brand: _____ Date: _____
- Others: _____ ☐ Yes ☐ No Date: _____

FAMILY MEDICAL HISTORY

Please indicate if your mother (m), father (f), sister (sis), brother (b), daughter (d), son (son) has a history of the following.

- ☐ Alcohol abuse Who? _____
- ☐ Anesthesia complications Who? _____
- ☐ Anxiety Who? _____
- ☐ Asthma Who? _____
- ☐ Blood clots Who? _____
- ☐ Breast cancer, how old: _____ Who? _____
- ☐ Colon cancer, how old: _____ Who? _____
- ☐ Cancer, other: _____ Who? _____
- ☐ Depression Who? _____
- ☐ Diabetes, how old: _____ Who? _____
- ☐ Drug abuse Who? _____
- ☐ Eczema Who? _____
- ☐ Heart attack, how old: _____ Who? _____
- ☐ High blood pressure Who? _____
- ☐ High cholesterol Who? _____
- ☐ Kidney disease Who? _____
- ☐ Lung problems Who? _____
- ☐ Melanoma Who? _____
- ☐ Migraines Who? _____
- ☐ Osteoporosis Who? _____
- ☐ Other mental illness Who? _____
- ☐ Prostate cancer, how old: _____ Who? _____
- ☐ Seizures Who? _____
- ☐ Stroke, how old: _____ Who? _____
- ☐ Thyroid trouble Who? _____
- ☐ Other: _____ Who? _____

If your father is deceased, how old was he when he died? _____ What did he die from? _____

If your mother is deceased, how old was she when he died? _____ What did she die from? _____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Please indicate your marital or relationship status.

☐ Single ☐ Married since: _____

☐ Not married, stable partner since: _____

☐ Separated since: _____

☐ Divorced since: _____

☐ Widowed since: _____

What is your gender identity? _____

SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

What is the gender of your sexual partner(s)? _____

Age you became sexually active: _____

Number of sexual partners in the last year: _____

What is your sexual orientation? _____

ALCOHOL & DRUG USE

On average, how many alcoholic beverages do you drink per week? _____

Men under 65:
How many times in the past year have you had 5 or more drinks in a day?

☐ None ☐ 1 or more

Women (and men over 65):
How many times in the past year have you had 4 or more drinks in a day?

☐ None ☐ 1 or more

How many times in the past year have you used a recreational drug or a prescription medication for non-medical reasons?

☐ None ☐ 1 or more

TOBACCO USE

☐ I have never used tobacco

☐ I have smoked, started at age: _____

☐ I still smoke _____ packs per day

☐ I quit _____ (date) but used to smoke _____ packs per day

☐ I have tried to quit _____ times

☐ I chew or use smokeless tobacco

☐ I vape or use e-cigarettes

☐ I am exposed to second-hand smoke

OCCUPATION

☐ Currently employed at: _____

Doing: _____

_____ Since: _____

☐ Homemaker since: _____

☐ Retired since: _____

☐ Former job: _____

☐ Disabled due to: _____ Since: _____

HEALTHY HABITS

In general, how many days do you exercise per week? _____

On those days, how long do you exercise? _____ minutes

When you exercise, what is the intensity?

☐ Mild (stretching or slow walking)

☐ Moderate (brisk walking)

☐ Heavy (jogging or swimming)

☐ Vigorous (fast running or stair climbing)

☐ Combination

COLORECTAL HEALTH

Date of most recent colonoscopy: _____

Was it normal? ☐ Yes ☐ No

Date of other colorectal cancer screening: _____

Was it normal? ☐ Yes ☐ No

WOMEN'S HEALTH

Have you ever had an abnormal pap test? ☐ Yes ☐ No

When was your last pap? _____

Was it normal? ☐ Yes ☐ No

When was your last mammogram? _____

Was it normal? ☐ Yes ☐ No

When was your last bone density (DEXA) scan? _____

Was it normal? ☐ Yes ☐ No

ADVANCED CARE PLANNING

Have you filled out forms to indicate your desires for end of life care?

Living Will: ☐ Yes ☐ No

Durable power of attorney for healthcare ("DPOA"):

☐ Yes ☐ No If yes, who: _____

Patient Name: _____ Date of Birth: _____

COMPREHENSIVE REVIEW OF SYSTEMS

Please check the boxes of any symptoms you have had in the past 2 weeks.

General
- ☐ Fatigue
- ☐ Fevers
- ☐ Loss of appetite
- ☐ Unplanned weight gain
- ☐ Unplanned weight loss

Skin
- ☐ New sore or lesion
- ☐ Non-healing sores
- ☐ Rashes

Eyes/Ears/Nose/Throat/Mouth
- ☐ Began wearing glasses or contacts
- ☐ Change in vision
- ☐ Bad teeth
- ☐ Dentures
- ☐ Frequent stuffy nose
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Seasonal allergies
- ☐ Sinus pain
- ☐ Snoring

Lungs
- ☐ Breathing problems
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing

Breasts
- ☐ Breast lump
- ☐ Breast pain

Cardiovascular
- ☐ Chest pain or pressure
- ☐ Heart beats fast
- ☐ Heart skips
- ☐ Short of breath with exercise
- ☐ Short of breath lying down
- ☐ Waking at night short of breath
- ☐ Swelling or edema

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black tarry stool
- ☐ Blood in stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea

Gastrointestinal, continued
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Bleeding after menopause
- ☐ Blood in urine
- ☐ Difficulty holding urine
- ☐ Difficulty urinating
- ☐ Excessive urination at night
- ☐ Pain or burning with urination
- ☐ Sexual health concerns
- ☐ Trouble with periods

Muscles and Skeleton
- ☐ Backache
- ☐ Muscle pain
- ☐ Painful joints

Endocrine
- ☐ Excessive thirst
- ☐ Hot flashes

Neurological
- ☐ Fainting or passing out
- ☐ Headaches
- ☐ Memory loss
- ☐ Numbness or tingling
- ☐ Sense of room spinning
- ☐ Tremor
- ☐ Unsteadiness or imbalance
- ☐ Weakness

Mental Health
- ☐ Change in sleep pattern
- ☐ Feeling nervous, anxious or on edge

Blood
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen glands

Other: _____

_____

_____

_____

_____

DEPRESSION SCREENING (PHQ-2)

Over the past two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half of the days	Nearly every day
Little interest or pleasure in doing things:	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed or hopeless:	☐ 0	☐ 1	☐ 2	☐ 3

SLIDING SCALE DISCOUNT PROGRAM

Compassionate financial support

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient's ability to pay. Discounts are offered based on family size and annual income.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

The application can be completed online by using the QR codes below, or you can request a paper application from any front desk team member.

These documents will need to be turned in before your application can be processed: Completed Application and Proof of Income

Applications need to be received within 30 days of your first appointment.

Family Health Centers
Financial Advocate
Phone: (828) 771-5502 | Fax: (828) 579-4208

Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

Ob/Gyn Specialists
Financial Advocate
Phone: (828) 771-5443 | Fax: (828) 407-2639

Mailing Address:
119 Hendersonville Rd, Asheville, NC 28803

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771- 5466 | Fax: (828) 579-4212

Mailing Address:
125 Hendersonville Rd, Asheville, NC 28803

Dental Health Centers
Financial Advocate
Phone: (828) 398-5918 | Fax: (828) 552-8691

Mailing Address:
123 Hendersonville Rd. Asheville, NC 28803

Internal Medicine
Financial Advocate
Phone: (828) 771-3507 | Fax: (828) 579-3748

Mailing Address:
123 Hendersonville Rd, Asheville, NC 28803

English **Español**

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate

INCOMING TO MAHEC

MAHEC

MRN: _____

Centralized Medical Records Department

121 Hendersonville Road, Asheville, NC 28803 | Business Office Phone: (828) 771-5489 | Fax: (828) 407-2637

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

Patient Name: _____Date of Birth:_____

I authorize the use or disclosure of the above named individual's health information as described below.

The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY:	MAHEC Centralized Medical Records Department ❑ Family Medicine ❑ OB/Gyn ❑ Internal Medicine ❑ Dental ❑ Psychiatry ❑ Community Pharmacy
ADDRESS:	**121 Hendersonville Road**
CITY/STATE: PHONE #: FAX #:	**Asheville, NC 28803**

The purpose or need for this disclosure is:

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

Information to be disclosed: *(check appropriate box(es))*

❑ Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)

❑ Only information related to *(specify)*: _____

❑ Only the period of events from: _____ to _____

❑ Entire medical record

❑ Exclusions
- __ AIDS/HIV test results, diagnosis, treatment, and related information
- __ Drug screen results and information about drug and alcohol use and treatments
- __ Mental health notes
- __ Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. _____

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

By signing below, I acknowledge that I have read and understand this Authorization.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE *(State relationship to Patient)*	DATE
WITNESS TO SIGNATURE, IF APPLICABLE	DATE

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.