



## Center for Psychiatry and Mental Wellness



### WELCOME TO OUR PRACTICE

We are happy you have chosen us for your care!

All of our providers and team members look forward to welcoming you to our practice! We have enclosed the necessary paperwork for you to complete before your visit.

#### OFFICE HOURS

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

#### AFTER HOURS

Providers are on call and you can leave a message for the provider by calling the office number and choosing the prompt for the on-call service. This should be used for urgent matters only. Non urgent calls such as appointment scheduling and medication refill requests should be made during office visits or by calling the office during business hours. For mental health and medical emergencies, you should call 911 or reach out to RHA Mobile Crisis Services at 888-573-1006.

#### OUR COMPREHENSIVE MENTAL HEALTH SERVICES INCLUDE

- Medication Management
- Psychotherapy
- Intellectual and developmental disabilities (IDD) behavioral health support
- Substance use disorder treatment
- Medication for opioid use disorder
- Transcranial Magnetic Stimulation (TMS)
- Peer Support Services
- Collaborative Care Management Programs
- School Based Therapy
- Acceptance and commitment therapy
- Cognitive behavioral therapy
- Mindfulness-based stress management
- On-site laboratory services
- Parent-child interaction therapy
- Play therapy
- Long acting injectable medication support
- Trauma-informed care

#### MAHEC Center for Psychiatry and Mental Wellness

Mary C. Nesbitt Biltmore Campus, 125 Hendersonville Road, Asheville, NC 28803

Phone: 828-398-3601 | Fax: 828-333-5465



## 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](http://www.mahec.net)**



**NEW PATIENTS**

New patients need to bring completed paperwork, a picture ID and insurance cards to first appointment. Patients are encouraged to contact their insurance company and verify mental health benefits prior to their first visit. We accept all insurance, but this does not guarantee that we are in network with your plan.

**RETURNING PATIENTS**

Returning patients should make sure all information is up to date at each visit. This includes name, address, phone number and insurance information.

**TELEPHONE CONSULTATIONS**

Telephone consultations are generally not available. Please discuss your healthcare needs during your visit. Should issues arise between appointments please contact our office to schedule an earlier appointment.

**AFTER HOURS**

One of our providers will be on call and you can leave a message for the provider by calling the office number and choosing the prompt for the on-call service. This should be used for urgent matters only. Non urgent calls such as appointment scheduling and medication refill requests should be made during office visits or by calling the office during business hours. For medical emergencies, you should call 911.

**PRESCRIPTION REFILLS**

All medication refill requests need to be made during the patient’s appointment. Please bring prescription bottles or a list of medications with you to each appointment. Prescription refill requests at other times will be completed within 3 business days.

**BILLING**

You are responsible for your annual deductible, co-pay/co-insurance, and any balance that your insurance does not pay. Co-pays are expected at the time of service. Please be aware that some services are not covered by insurance and you will be billed. We accept cash, check, and credit card payments. A service fee is assessed for returned checks. The billing office phone number is (828) 257-4725, option 3. If you have a billing question, please call the billing office and we will do our best to help you or direct you to someone who can.

I have read and agree to the above policy:

\_\_\_\_\_  
Printed Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Today’s Date

\_\_\_\_\_  
Signature

*Thank you for choosing us for your healthcare!*





# 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:

\_\_\_\_\_

Uses Wheelchair:  Yes  No

Special Vision Needs:

\_\_\_\_\_

Speech Impaired:  Yes  No

Veteran Status:  Yes  No

### Race (select one):

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Other Pacific Islander
- Guamanian/Chamorro
- Samoan
- Black/African American
- American Indian/Alaska Native
- White
- More than one race

### Gender Identity:

- Male
- Female
- Transgender Male
- Transgender Female
- Other
- Choose not to disclose

### Marital Status:

- Single
- In a relationship
- Partner
- Married
- Separated
- Divorced
- Widowed

### Sexual Orientation:

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

### Special Populations

- Migratory  Yes  No
- Seasonal  Yes  No
- Homeless  Yes  No

Homeless Status (select one):

- Not Homeless
- Homeless Shelter
- Transitional
- Doubling Up
- Street
- Permanent Supportive Housing
- Other

### Ethnicity (select one):

- Mexican/Mexican American/Chicano
- Puerto Rican
- Cuban
- Hispanic/Latino/Spanish
- Non-Hispanic/Latino/Spanish

### Preferred Language:

- English
- Spanish
- Russian
- American Sign Language
- Other: \_\_\_\_\_

**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.

**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







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





# Center for Psychiatry and Mental Wellness New Patient Intake Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Form Completed by: \_\_\_\_\_

## 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: \_\_\_\_\_

## FAMILY MEDICAL HISTORY

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? \_\_\_\_\_

## SURGICAL HISTORY

Please list the date(s) and description(s) of any past surgeries you have had:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## REPRODUCTIVE LIFE PLANNING

Would you like to become pregnant in the next year?

Yes  No  Okay either way  Unsure

Are you using any method to prevent pregnancy?

Yes  No

If yes, what: \_\_\_\_\_

## 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: \_\_\_\_\_

### FAMILY MEDICAL HISTORY

Please check the appropriate box if any of your blood-relatives have been diagnosed with or experienced the following mental health problems.

	Mother	Father	Sister	Brother	Daughter	Son
Alcohol Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder or Panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder, Manic Episodes, or Manic Depressive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual or Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Major Depression or Clinical Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive-Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post-Traumatic Stress Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia, Schizoaffective Disorder, or another Paranoid or Delusional Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completed Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Mental Health Condition (please specify) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



Child's Name \_\_\_\_\_  
 Today's Date \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

Record Number \_\_\_\_\_  
 Filled out by \_\_\_\_\_

## Pediatric Symptom Checklist Ages 4-10

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	_____	_____	_____
2.	Spends more time alone	2	_____	_____	_____
3.	Tires easily, has little energy	3	_____	_____	_____
4.	Fidgety, unable to sit still	4	_____	_____	_____
5.	Has trouble with a teacher	5	_____	_____	_____
6.	Less interested in school	6	_____	_____	_____
7.	Acts as if driven by a motor	7	_____	_____	_____
8.	Daydreams too much	8	_____	_____	_____
9.	Distracted easily	9	_____	_____	_____
10.	Is afraid of new situations	10	_____	_____	_____
11.	Feels sad, unhappy	11	_____	_____	_____
12.	Is irritable, angry	12	_____	_____	_____
13.	Feels hopeless	13	_____	_____	_____
14.	Has trouble concentrating	14	_____	_____	_____
15.	Less interest in friends	15	_____	_____	_____
16.	Fights with others	16	_____	_____	_____
17.	Absent from school	17	_____	_____	_____
18.	School grades dropping	18	_____	_____	_____
19.	Is down on him or herself	19	_____	_____	_____
20.	Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21.	Has trouble sleeping	21	_____	_____	_____
22.	Worries a lot	22	_____	_____	_____
23.	Wants to be with you more than before	23	_____	_____	_____
24.	Feels he or she is bad	24	_____	_____	_____
25.	Takes unnecessary risks	25	_____	_____	_____
26.	Gets hurt frequently	26	_____	_____	_____
27.	Seems to be having less fun	27	_____	_____	_____
28.	Acts younger than children his or her age	28	_____	_____	_____
29.	Does not listen to rules	29	_____	_____	_____
30.	Does not show feelings	30	_____	_____	_____
31.	Does not understand other people's feelings	31	_____	_____	_____
32.	Teases others	32	_____	_____	_____
33.	Blames others for his or her troubles	33	_____	_____	_____
34.	Takes things that do not belong to him or her	34	_____	_____	_____
35.	Refuses to share	35	_____	_____	_____

Total score \_\_\_\_\_

Does your child have any emotional or behavioral problems for which she/he needs help?    ( ) N    ( ) Y  
 Are there any services that you would like your child to receive for these problems?    ( ) N    ( ) Y

If yes, what services? \_\_\_\_\_



**Pediatric Symptom Checklist - Youth Report (Y-PSC) Ages 11-16**

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches or pains.....	—	—	—
2. Spend more time alone.....	—	—	—
3. Tire easily, little energy.....	—	—	—
4. Fidgety, unable to sit still.....	—	—	—
5. Have trouble with teacher.....	—	—	—
6. Less interested in school.....	—	—	—
7. Act as if driven by motor.....	—	—	—
8. Daydream too much.....	—	—	—
9. Distract easily.....	—	—	—
10. Are afraid of new situations.....	—	—	—
11. Feel sad, unhappy.....	—	—	—
12. Are irritable, angry.....	—	—	—
13. Feel hopeless.....	—	—	—
14. Have trouble concentrating.....	—	—	—
15. Less interested in friends.....	—	—	—
16. Fight with other children.....	—	—	—
17. Absent from school. ....	—	—	—
18. School grades dropping. ....	—	—	—
19. Down on yourself.....	—	—	—
20. Visit doctor with doctor finding nothing wrong.....	—	—	—
21. Have trouble sleeping.....	—	—	—
22. Worry a lot.....	—	—	—
23. Want to be with parent more than before.....	—	—	—
24. Feel that you are bad.....	—	—	—
25. Take unnecessary risks.....	—	—	—
26. Get hurt frequently.....	—	—	—
27. Seem to be having less fun.....	—	—	—
28. Act younger than children your age.....	—	—	—
29. Do not listen to rules.....	—	—	—
30. Do not show feelings.....	—	—	—
31. Do not understand other people's feelings.....	—	—	—
32. Tease others.....	—	—	—
33. Blame others for your troubles.....	—	—	—
34. Take things that do not belong to you.....	—	—	—
35. Refuse to share.....	—	—	—



## 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*





**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.

<b>The information is to be disclosed by:</b>	<b>And is to be provided to:</b>
NAME OF FACILITY:	MAHEC Centralized Medical Records Department <input type="checkbox"/> Family Medicine <input type="checkbox"/> OB/Gyn <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Dental <input type="checkbox"/> Psychiatry <input type="checkbox"/> Community Pharmacy
ADDRESS:	121 Hendersonville Road
CITY/STATE:	Asheville, NC 28803
PHONE #: _____ FAX #: _____	

**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.**

<b>SIGNATURE OF PATIENT</b>	<b>DATE</b>
<b>SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE (State relationship to Patient)</b>	<b>DATE</b>
<b>WITNESS TO SIGNATURE, IF APPLICABLE</b>	<b>DATE</b>

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