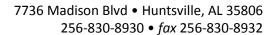
INJURY CARE REGISTRATION

First Name	Middle	Last Name (include Jr., Sr. III, etc.) Today's date			
ADDRESS		DEMOGRAPHIC INFORMATION			
ADDRESS					
STREET/PO BOX: CITY STATE: ZIP:		Our office participates in a federal program that requires us to record demographic information about our patients,			
CITY 3	TATE: ZIP:	including preferred language, race and ethnicity.			
CONTACT INFORMATION		DEMOGRAPHIC INFORMATION – LANGUAGE Please indicate your preferred language.			
Home Phone No:		○ English			
Mobile Phone No:		Spanish			
Work Phone No:		Other (specify):			
		Other (specify).			
Birth Date:		DEMOGRAPHIC INFORMATION – RACE Please select one or more to indicate your race. You may decline to answer this question.			
Social Security Number:		American Indian/Alaska Native			
MARITAL STATUS:		Asian			
○ Single		Black or African American			
○ Married		Hispanic or Latino			
Divorced		Native Hawaiian/Other Pacific Islander			
		○ White			
○ Widow/Widower		○ I decline to answer			
EMERGENCY CONTACT		DEMOGRAPHIC INFORMATION – ETHNICITY			
		Please indicate your ethnicity. You may decline to answer			
Name:		this question. Hispanic or Latino			
Telephone Number:					
Relationship:		Not Hispanic or Latino			
		I decline to answer			
CONSENT FOR ELECTRONIC PRES	CRIBING				
Our practice uses an electronic sy					
between our office and your pha your health care provider to see i					
that you are already taking that r					
other health care providers. By s					
allow your health care provider to system to view this information.	o use the electronic prescribing				
Patient	Signature	-			
r dtient .	Jigilature				





General Consent for Treatment

I consent to have treatment or physical examination/ testing performed by the physician, nurse practitioner and professional staff at Crestwood Workers Care. I permit the provider to treat me in ways they judge are beneficial to me. I understand that this care may include examinations, x-rays, other tests, and the drawing of my blood.

Consent is given by: Patient unable to consent because: I, therefore, consent for the patient. Relationship to patient:	□ Other
☐ Yes ☐ No I give permission for my medical inform numbers listed in my chart. The followinformation over the phone:	
□ Yes □ No	
I give permission for my medical information	on to be left in the form of a voicemail.
☐ Yes ☐ No I give my permission to allow my healthcar from my pharmacy, my health plans, and n	re provider to obtain my medication history my other healthcare providers.
Signature:	Date:
HIPAA Privacy Act I hereby acknowledge that I have been Practices of Crestwood Workers Care.	provided with a copy of the notice of Privacy
Signature of Patient or Authorized Party: _ Date:	
Time:	□ AM □ PM
If above signature is other than Patient, re	lationship to patient:
Interpreter, if utilized:	



1ROI

All portions of this form <i>must</i> be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.				
Patient's Name	· · · · · · · · · · · · · · · · · · ·	Date of Birth	Medical Record Number	
Address	City, State, Zip		Telephone Number	
I authorize the use and disclosure of health inform	ation about me as o	lescribed below:		
Facility Authorized to Release my Health Information				
Agency or Individual(s) Authorized to Receive my Health Information				
Address	City, State, Zip		Telephone Number	
	nited to the following: Consultation(s) X-ray Reports	☐ Progress Notes ☐ Lab ☐ Entire Record	☐ Emergency Room Record ☐ Pathology Report ☐ Other (specify)	
Health Information that may be used / disclosed is lin From (date):To (date):	nited to the following p	periods of healthcare Account Nur Account Nur	: nber: nber:	
Health information to be released to the above name Treatment/Consultation At Request of Employer Other	d agency / individual i			
I hereby discharge the releasing facility, its agents an which might arise from the release of information aut including HIV status, and/or psychiatric diagnose thereof in accordance with the policies of this facility. If applicable, I agree to the release of my medical or bil	horized herein, to in s compiled during m	clude alcohol, dru y visit, encounter or	g abuse, communicable disease hospitalization, or make copies	
Protected Health Information used or disclosed pursual longer protected by this privacy rule. If research-related expiration date or event does not apply.	nt to this authorization	n may be subject to r	e-disclosure by the recipient and is no	
This authorization will automatically <u>expire 60 days</u> after is specified, or at the conclusion of a specified event. It as stated in the Notice of Privacy Practices, except who authorization.	understand that I have	e a right to revoke th	is authorization at any time, in writing,	
Treatment, payment, enrollment or eligibility for benefits Portability Accountability Act prohibits such conditioning of care or coverage.	s may not be condition g. If conditioning is pe	ned on obtaining an a rmitted, refusal to sig	authorization if the Health Insurance gn the authorization may result in denia	
NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: Portability and Accountability Act (HIPAA) privacy reg		o be treated in acco	ordance with Health Insurance	
Patient's or Authorized Personal Representative's Signature*		Date	Time	
Relationship to Patient / Authority to Act on Patient's Behalf		Interpreter, if Uti	lized	
Witness's Signature		Expiration Date		
□ *Signature validated against driver's license or signature Authorization to Use and Disclose		ere may be a charge fo	or copying Medical Records.	
Protected Uselth Information	abel			

Authorization to Use and Disclose
Protected Health Information
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WHITE - Medical Record CANARY - Recipient

Patient Labe