WILMINGTON HEALTH
wilmingtonhealth.com

Demographics

Please print, complete all fields, and sign.

Office Use Only: Recorded By: _____ Date: _____

Patient Last Name_____ Suffix_____ First_____ Middle_____

Prior Last Name_____Nickname_____SSN_____Birthdate_____ Male____ Female_____

Billing or PO Box Address

Street_____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

County_____ Country: US_____ Other_____

Secondary or Physical Address

Street_____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

County_____ Country: US: _____Other_____

Primary Care Provider_____ Marital Status_____ Race_____ Language_____ Ethnicity_____

1-Primary Insurance Name _____

Policy ID#_____ Group#_____

Insurance Address_____

City_____ State_____ Zip_____

Policy Holder (Sponsor) Name_____

Birthdate_____ Sex_____ Phone_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

Policy Holder's Relationship to Patient_____

Employer_____

2-Secondary Insurance Name _____

Policy ID#_____ Group#_____

Insurance Address_____

City_____ State_____ Zip_____

Policy Holder (Sponsor) Name_____

Birthdate_____ Sex_____ Phone_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

Policy Holder's Relationship to Patient_____

Employer_____

Patient Contact Information

Home Phone_____ Cell_____

Day Phone_____ Alternate_____

Preferred Contact (check 1) Home____ Cell____ Work____ Portal____

Preferred Notification (check 1) Phone___ Text___ Voice Reminders____

E-Mail_____ Decline E-Mail____

Patient Portal (check 1) Desires registration____ Already registered____

Mother's Information (of patient under 18)

First Name_____ Middle_____

Last_____ SSN_____

Phone_____ Birthdate_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

E-Mail_____ Decline E-Mail____

Father's Information (of patient under 18)

First Name_____ Middle_____

Last_____ Suffix____ SSN_____

Phone_____ Birthdate_____

Street _____ Apt/Bldg/Lot_____

City_____ State_____ Zip_____

E-Mail_____ Decline E-Mail____

Emergency Contact Information

First Name_____ Middle _____Last_____ Relationship_____

Street _____City_____State_____Zip_____

Birthdate _____Home Phone _____Cell _____Work_____

(1) I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost of the interest, collection and legal action (if required). (2) We are required by applicable federal and state law to maintain the privacy of your medical information. Our Notice of Privacy Practices document informs you of our notice at any time. (3) My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to Wilmington Health. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will insure such payment to Wilmington Health.

	Print Name	**Sign Name** (Signature Required)	**Relationship to Patient**	**Date**
Patient				
Responsible Party (Of Patient Under 18 Or HealthCare POA)				

A copy of this authorization and assignment shall be considered as valid as the original.

1202 Medical Center Dr.
Attn: Medical Records
Wilmington, NC 28401
Phone: 910-341-3308
Fax Requests to: 910-341-3419
Fax Records to: 910-341-1900

Authorization for Use, Disclosure, and/or Request of Protected Health Information

Patient Name: _____

Date of Birth_____ Last four digits of Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Specific information being requested:

- ☐ History/Office notes
- ☐ Laboratory test results
- ☐ Pap Smears
- ☐ Mammograms
- ☐ Immunizations
- ☐ Colonoscopy and/or EGD reports including associated pathology reports
- ☐ Radiology reports (includes Bone Density, CT/CTA, MRI/MRA, Vascular, etc.)
- ☐ Cardiology studies
- ☐ Other: (Please be specific as we will only be able to provide the information you list)

_____

Time Frame of records to be released: (examples: 1 year, 2016 – current, most recent, or last 3 visits)

_____

Unless initialed the following information will NOT be released or disclosed:

_____ HIV/AIDS/Communicable Disease Status

_____ Alcohol and/or Drug Abuse or Treatment

_____ Mental Health Status or Treatment

Entities Authorized to Use, Disclose, or Receive: If persons or organizations authorized below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Records Requested FROM:	**Records Being Sent TO:**
Name of Provider or Organization:	Name of Provider or Organization:
_____	_____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax: _____

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Preference for receipt of records:

- ☐ Regular Mail
- ☐ Fax: _____ (maximum 50 pages)
- ☐ Electronic Copy (disk) (State regulated Hi-Tech fee of $6.50 applies)
- ☐ Pick up by: _____ at location _____

The purpose of the Use, Disclosure, and/or Request: (State regulated fees apply)

- ☐ Changing Provider/Continuation of Care
- ☐ Insurance
- ☐ Attorney
- ☐ Personal Use ($10 minimum, $50 maximum for paper copies)
- ☐ Other: _____

This Authorization will expire: (choose one)

- ☐ 2 years after death of patient
- ☐ Upon written revocation
- ☐ Future Date: _____
- ☐ On the occurrence of the following event: _____

By signing below, I understand:

- I authorize the use and/or disclosure of my protected health information as described in this document.
- I may revoke this authorization at any time by providing written notice of my revocation. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before notice of revocation of authorization was received.
- I may refuse to sign this authorization and the request will be considered null and void.
- Wilmington Health may not condition my treatment on my refusal to sign this authorization.

Signature: _____

Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

If you have concerns about your privacy rights, please contact Wilmington Health Privacy Officer:
Phone: 910-796-7701 Fax: 910-772-1307 Address: 1202 Medical Center Dr. Wilmington, NC 28401
Email: privacyofficer@wilmingtonhealth.com