

PATIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Which health center do you prefer? ☐ Grass Valley ☐ Penn Valley ☐ Auburn ☐ Kings Beach ☐ Downieville

The following information will help you and your provider focus on the health topics and concerns that are affecting you or are more likely to affect you. Please fill out the questions as completely as possible.

## PERSONAL MEDICAL HISTORY

Please indicate each of your medical problems by marking the appropriate box below:

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> ADD: If Yes? →                           | <input type="checkbox"/> History       | <input type="checkbox"/> Currently Experiencing      | <input type="checkbox"/> Current Prescription |
| <input type="checkbox"/> Anxiety: If Yes? →                       | <input type="checkbox"/> History       | <input type="checkbox"/> Currently Experiencing      | <input type="checkbox"/> Current Prescription |
| <input type="checkbox"/> Chronic Pain: If Yes? →                  | <input type="checkbox"/> History       | <input type="checkbox"/> Currently Experiencing      | <input type="checkbox"/> Current Prescription |
| <input type="checkbox"/> Depression: If Yes? →                    | <input type="checkbox"/> History       | <input type="checkbox"/> Currently Experiencing      | <input type="checkbox"/> Current Prescription |
| <input type="checkbox"/> Other Mental Health Diagnosis: If Yes? → | <input type="checkbox"/> History       | <input type="checkbox"/> Currently Experiencing      | <input type="checkbox"/> Current Prescription |
| <input type="checkbox"/> Cancer (If yes, what type?) _____        |  |  |   |
| <input type="checkbox"/> Current Suicidal Thoughts? _____         |  |  |   |
| <input type="checkbox"/> Angina                                   | <input type="checkbox"/> Glaucoma      | <input type="checkbox"/> Hemorrhoids/Rectal Bleeding | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Arthritis                                | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Hernia                      | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Head Injury   | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Seizures/Epilepsy    |
| <input type="checkbox"/> Cataracts                                | <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Stomach Ulcers       |
| <input type="checkbox"/> Colon Polyps                             | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Irritable Bowel             | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Emphysema/Lung Disease                   | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Thyroid Disease      |
|   |  |  | <input type="checkbox"/> Tuberculosis         |

List all surgeries and hospitalizations (including psychiatric hospitalization):

Type	Year	Medical	Psychiatric	Hospital, City, State
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	

Are you allergic to any medications or foods? Please list and note your reaction:

Food/Medication	Reaction

Do you see any other medical providers or specialists currently? If so, please list their names and what services or medications they are providing to you. **Please complete a records request for each provider/specialist.**

Name	Service/Medications

Please list all medications that you are taking, including strength, and how often. Include all non-prescription medications, vitamins and herbal supplements. Please include any medications you have taken in the last 6 months. If you need more room, please attach additional list.

Name	Strength	How often	Condition	Currently Taking?

## PREVENTIVE HEALTH CARE

### A. Year of Last Vaccine:

Tetanus: \_\_\_\_\_ Pneumonia: \_\_\_\_\_ Pneumovax: \_\_\_\_\_ Prevnar 13: \_\_\_\_\_ Flu: \_\_\_\_\_ Shingles: \_\_\_\_\_  
Have you had Chicken Pox? ☐ Yes ☐ No Have you been vaccinated for Chicken Pox? ☐ Yes ☐ No

### B. Colonoscopy:

Year of last Colonoscopy: \_\_\_\_\_ Doctor: \_\_\_\_\_

### C. Women Only:

Date of last Mammogram: \_\_\_\_/\_\_\_\_/\_\_\_\_; Doctor: \_\_\_\_\_  
Date of last PAP: \_\_\_\_/\_\_\_\_/\_\_\_\_; Doctor: \_\_\_\_\_  
Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_; Have you had a hysterectomy? \_\_\_\_\_ Full ☐ Partial ☐  
Are you pregnant? \_\_\_\_\_ OB Doctor: \_\_\_\_\_

### D. Men Only:

Date of last Prostate Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_; Doctor: \_\_\_\_\_  
Date of last PSA (Prostate Blood Test): \_\_\_\_/\_\_\_\_/\_\_\_\_; Doctor: \_\_\_\_\_

### E. Bone Density

Have you had a Bone Density Test? Yes ☐ No ☐ If so, when? \_\_\_\_/\_\_\_\_/\_\_\_\_ Doctor: \_\_\_\_\_

### F. Smoking

Are you a smoker? Yes ☐ No ☐  
If you smoke, how many cigarettes do you smoke a day? \_\_\_\_\_ Are you interested in quitting? Yes ☐ No ☐  
How soon after you wake up in the morning do you smoke your first cigarette? \_\_\_\_\_

### G. Alcohol

Do you drink alcohol? Yes ☐ No ☐ How many drinks do you have in a day? \_\_\_\_\_

### H. Drugs

Do you use any drugs, such as marijuana (cannabis), cocaine, heroin, etc.?

Name	Past Use	Currently Using

### I. Diabetes

Are you diabetic? Yes ☐ No ☐ Date of last A1C: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of last eye exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Do you do daily foot exams? Yes ☐ No ☐

Do you have any disabilities that you would like us to know about?

<input type="checkbox"/> Disability related to vision	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Disability related to hearing	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Disability related to communication	<input type="checkbox"/> I am requesting an appointment for paperwork for disability

If so, what reasonable accommodations could we make to assist you (for example, large print education materials or accommodations for a wheelchair).

Do you have a living will or advanced directive? ☐ Yes ☐ No

If no, are you interested in speaking with a staff member about this? Yes ☐ No ☐

Do you have a conservator/legal guardian or proxy? Yes ☐ No ☐

Please indicate the reason you are here today: \_\_\_\_\_

## FAMILY MEDICAL HISTORY

If any blood relative has suffered from the following conditions, check the box and **indicate which relative**:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Emphysema/Lung Disease	<input type="checkbox"/> Mental Health Condition
<input type="checkbox"/> Thyroid	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Alzheimer's/ Dementia	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Cancer (If yes, what type?)	

## FEEDBACK

How did you hear about Western Sierra Medical Clinic?

☐ Newspaper ☐ Facebook ☐ Referral from medical provider ☐ Radio ☐ Neighbor/friend ☐ Other: \_\_\_\_\_

It may take some time to obtain and review your health information and enroll you as a patient.

**If you have an immediate need, please visit our Urgent Care unit.**

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.



PATIENT INFORMATION				
First Name	Middle Name	Last Name	Other Name	
Physical Address		City	State	Zip
Mailing Address		City	State	Zip
Home Phone <input type="checkbox"/> Text Enabled	Work Phone		Cell Phone <input type="checkbox"/> Text Enabled	
<input type="checkbox"/> I give WSMC permission to leave detailed messages concerning my care on my voicemail. Number:				
Date of Birth	Social Security #	Email Address	<input type="checkbox"/> Create Patient Portal Account	
Emergency Contact	Emergency Contact Phone		Relationship to Emergency Contact	
Name of Father/Guardian:		Name of Mother/Guardian:		
Is anyone else authorized to bring your child in for a visit? If so, Name and Relationship to Patient: _____ Does this person have legal authority to consent to treatment and receive protected health information pertaining to your child? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is there anyone with whom you want us to share protected health information pertaining to your child? If so, Name and Relationship to Patient:		
Patient Race: <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> White <input type="checkbox"/> Filipino <input type="checkbox"/> Other Asian <input type="checkbox"/> Samoan <input type="checkbox"/> Unreported			Patient ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused to Report	
Sexual Orientation: <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Don't know		Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other		
Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female				
Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a migrant farm worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you homeless?*	How did you hear about WSMC?	
Primary Language		Family Size (household)	Annual Income (household)	
Date of Injury/Onset of Illness:	Are you here for an automobile accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you here for a work-related injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please explain the reason you are here today:				
Primary Care Provider (PCP): Note: You must follow up with your PCP after each urgent care visit		Primary Care Provider Phone		
*To be considered homeless, you must fit into one of the following categories: - Lacking a regular, adequate place to sleep at night. - Losing your primary nighttime residence within 14 days and not having an alternative. - Being an unaccompanied youth under 25 or part of a family with children who qualify under other Federal statutes. - Fleeing domestic violence and lacking permanent housing resources or support networks.				

GUARANTOR – PERSON RESPONSIBLE FOR PAYMENT			
<input type="radio"/> Mr.    Last Name                      First Name                      Middle <input type="radio"/> Mrs. <input type="radio"/> Miss	Relationship to Patient	Home Phone (       )	
Billing Address (if different from Patient's) City		State	Zip Code
Employed By	Job Title/Department	Work Phone Ext. # (       ) (       )	
Employer Address (Number and Street)	Guarantor's Social Security # --                      --	Guarantor's Date of Birth	
City	State	Zip Code	

PRIMARY INSURANCE INFORMATION		
Insurance Company	Policy Number	Group Number
Subscribers First Name	Subscribers Middle Name	Subscribers Last Name
Date of Birth	Social Security #	Employer

SECONDARY INSURANCE INFORMATION		
Insurance Company	Policy Number	Group Number
Subscribers First Name	Subscribers Middle Name	Subscribers Last Name
Date of Birth	Social Security #	Employer

PHARMACY CHOICE
<input type="checkbox"/> WSMC Pharmacy Located at 844 Old Tunnel Road in Grass Valley <input type="checkbox"/> Other: Pharmacy Name: _____ City: _____

CONSENT FOR MEDICAL TREATMENT
<p>The undersigned, as the above patient or as the parent, legal guardian or legal representative of the above patient, hereby consents to medical treatment of the above patient by Western Sierra Medical Clinic (WSMC) and its medical providers and clinical staff. Treatment may include any necessary examination, test or medical procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient to be performed by WSMC clinical staff. I understand and acknowledge this authorization is given in advance of any specific diagnosis, treatment or procedure being required to provide specific consent to any and all such diagnosis, treatment or procedure a WSMC medical provider in the exercise of his/her best judgment may deem advisable for the above patient.</p> <p>I understand the above patient may ask questions and have all questions answered and also may refuse treatment at any time.</p> <p>If the above patient is seeking substance abuse testing, I authorize WSMC to obtain a specimen pursuant to proper medical protocol to determine the presence of drugs or alcohol.</p> <p>I understand that some physical exams (like fitness for duty, school, or sports) and other services are not intended to diagnose medical conditions or replace the medical care of the above patient's personal physician.</p>

#### HEALTH INFORMATION EXCHANGE

Electronic Health Information Exchange (HIE) allows doctors, nurses and other health care providers to access and securely share a patient's vital medical information electronically, improving the speed, quality, safety and cost of patient care. Electronic health information systems can help prevent errors by ensuring that everyone involved in a patient's care—whether in a primary care setting, a specialists' office or emergency department—has access to the same information. HIE helps facilitate coordinated patient care, reduce duplicative treatments and avoid costly mistakes. This practice is growing among health providers because the need for HIE is clear and the HIE benefits are significant.

By default, all patients are "Opted In" in the HIE, meaning that once notified of the HIE, a patient must complete an Opt Out form if they do not wish to participate. A patient's health information will be available to all of the providers in the system who need it to provide care WITHOUT having to sign any further forms. Please see the receptionist if you would like a copy of this form or would like to request a change to your HIE options.

#### TELEMEDICINE

At WSMC, we offer telemedicine services as a convenient way to receive medical care through phone or video consultations. This method is cost-effective, saves time, reduces transportation barriers, and improves access to healthcare. Studies have also shown that telemedicine can improve the quality of healthcare.

However, it's important to note that telemedicine does have limitations. Telemedicine requires adequate privacy, technology, and service to conduct phone calls or video visits. In some circumstances, it may not be appropriate for conditions that require a physical examination.

Telemedicine visits costs can vary by insurance, however, the visit cost for telemedicine is no more than a standard office visit. You have the right to request more information about our telemedicine services. You may deny telemedicine visits and request an in-office consultation at any time during the scheduling process.

#### FINANCIAL RESPONSIBILITY

It is the patient's responsibility, and the responsibility of a patient's parent/legal guardian, to pay their share of charges for services provided by WSMC at the time of service, unless other arrangements are made in advance in writing signed by the patient and an authorized WSMC staff member. Payment of a patient's share can be in the form of insurance copays, deductibles, or cash payment for uninsured patients and cash pay patients. Patients not enrolled in health plans are responsible to pay for the entire amount of their bill. Patients enrolled in health plans are responsible for any amount the plan does not pay, up to the entire amount.

WSMC accepts cash, checks, and most major credit cards. A \$25.00 fee will be charged for the first check returned by the bank and a service fee of up to \$35 for each subsequent check returned by the bank to that same payee.

WSMC does not accept liens or other forms of promised payments for patients who are involved in work-related or personal injuries (e.g., automobile accidents). Patients pursuing claims for work-related or personal injury should consult with their employer and/or the appropriate insurance company for health care needs. WSMC will provide primary care services to a patient pursuing these claims as requested by the patient, but the patient remains responsible to pay for all such services in full. WSMC will not bill workers compensation, automobile or other similar insurance company.

#### IDENTITY AND INSURANCE VERIFICATION

Patients are required to provide WSMC with correct insurance information and to verify current personal information (home address, employer, phone number, insurance cards, and photo ID) at the each appointment check-in. It is important that you bring proof of insurance each time you visit. Failure to do so may result in you not being seen or being required to make a full payment at the time services are rendered.

#### WILLINGNESS TO PAY

No one will be denied services at WSMC due to inability to pay as long as there is a "willingness" to pay. Willingness to pay means either paying for services rendered (either through insurance with payment of patient copays and deductibles, cash pay, sliding fee scale) or a commitment to follow a written payment plan in order to pay off any outstanding balance in accordance with WSMC's policies and procedures.

An unwillingness to pay is demonstrated by a patient when the patient refuses to pay for services rendered (including copays, deductibles, and fees owed under the sliding fee scale discount program), refuses to commit to a written payment plan, or refuses to comply with a written payment plan signed by the patient.

Uninsured Patients needing financial assistance to pay for services should fill out a sliding fee scale application (see below) and may seek assistance from staff.

If a patient signs a written payment plan and has difficulty making payments under the plan, WSMC's Billing Department Supervisor is available to discuss amending the payment plan.

#### **SLIDING FEE**

For patients who qualify, a sliding scale discount may be applied to a patient's initial primary care, dental or behavioral health visit and for visits over the following six months. Patients who desire to apply for a sliding fee discount are required to complete an application, which explains WSMC's sliding fee scale discount program. Please ask a WSMC Billing Department staff member for the application and for an answer to any question regarding the sliding fee scale discount program.

#### **ASSIGNMENT OF BENEFITS**

I hereby irrevocably assign and/or convey directly to Western Sierra Medical Clinic, Inc. and/or its contracted healthcare providers (hereinafter "WSMC"), as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by WSMC for treatment/services rendered by WSMC, regardless of its managed care network participation status. This Assignment of Benefits shall apply to all insurance coverage, including but not limited to the Centers for Medicare and Medicaid Services, its intermediaries, carriers or administrative contractors, State Medicaid programs, or any other governmental or commercial insurance. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. This assignment is valid until revoked in writing. A photocopy of this assignment is to be considered valid, the same as if it was the original.

#### **ACKNOWLEDGEMENTS**

1. WSMC's notices, policies, and procedures are subject to change without notice. By receiving services at WSMC, I am subject to those changes unless I indicate in writing that I do not accept the changes. I may request copies of the current notices, policies and procedures.
2. WSMC's Notice of Privacy Practices is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to me upon request. I read and understand WSMC's Notice of Privacy Practices.
3. WSMC's Patient Rights and Responsibilities is posted in the lobby of each WSMC facility and on the WSMC website. A copy can be furnished to me upon request. I read and understand WSMC's Patient Rights and Responsibilities.
4. As a patient of WSMC, I have access to a medical provider 24 hours a day, seven days a week.
  - a. To access a medical provider after hours, call (530) 274-9762.
5. I may voice any concerns or grievances by contacting WSMC's Patient Advocate at (530) 274-9762 ext. 251.
6. I may not record, photograph or videotape inside a WSMC site.
7. I am solely responsible for safeguarding and protecting my personal property. WSMC is not responsible for safeguarding or for the theft, loss or damage to my personal property. I release all claims against WSMC for loss, theft or damage to my personal property.

#### **SIGNATURE**

I have read this form or have had it read to me in a language I can understand. I have had my questions about this form answered.

Signature or person giving consent or legal representation

Date

Print Name: \_\_\_\_\_

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Authorized Representative

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions



Western Sierra Medical Clinic (WSMC) is committed to providing quality of care to our clients and their families. We encourage patients to be aware of their rights and responsibilities as listed below:

### You Have the Right to:

1. Receive considerate, respectful, and culturally appropriate care based on professional standards of practice.
2. Receive services without discrimination on the basis of race, color, sex, marital status, religion, age, handicap, sexual orientation or preference, national origin, ancestry or diagnosis.
3. Establish advance directives and participate in ethical decision making.
4. Receive an explanation of your diagnosis, treatment, and prognosis in terms and language you can understand.
5. Receive the necessary information to participate in decisions about your care and to give your informed consent before any diagnostic or therapeutic procedure is performed.
6. Refuse any treatment, except as prohibited by law, and to be informed of the consequences of making this decision, which may include informing Children, Youth, and Family Services or Protective Services.
7. Expect that your personal privacy will be respected by all staff.
8. Expect that your medical records will be kept confidential and information will be released only with your written consent, in cases of medical emergencies, or in accordance with law.
9. Know WSMC policy for accessing and disclosing information in your medical records and reviewing your medical record, upon request, at a mutually designated time.
10. Receive a full explanation of any research or experimental procedure proposed for treatment and the opportunity to give your informed consent before any procedure will begin.
11. Know the name and qualification of all individuals providing service and how to contact that person.
12. Obtain another medical opinion prior to any procedure.
13. Have your legal custodian access your written medical records by appointment.
14. Ask for and receive information on your financial liability and an explanation of charges, including services that will be charged to your insurance.
15. File a complaint about services rendered without fear of discrimination from Western Sierra. Please call our Office Manager at (530) 274-9762 between 8:30 a.m. and 4:30 p.m.

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, sex, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.





### You are Responsible for:

1. Providing accurate personal, financial, insurance and medical information, including all medications and treatments, necessary to establish and follow your plan of care.
2. Asking questions if you do not understand the explanation of your diagnosis, treatment, prognosis or any instructions.
3. Informing WSMC of any requirements or accommodations needed to meet your cultural and/or language needs.
4. Following rules and regulations that are posted within WSMC while in the facility.
5. Not carrying any type of weapons when receiving treatment.
6. Not harming or being abusive to other persons including WSMC staff.
7. Keeping all scheduled appointments, arriving on time, and being able to participate in treatment.
8. Notifying WSMC with 24 hours' advance notice or as soon as you are aware that you cannot keep an appointment.
9. Informing WSMC health care professionals regarding any changes or reactions to medication and/or treatment.
10. Paying for services promptly including co-payments and total of cash charges at the time of service.
11. Advising WSMC of any problems or dissatisfaction with the service being provided.
12. Extending to WSMC staff the same courtesy given to you.
13. Developing and participating in your treatment planning.
14. Providing for the supervision and safety of your children while in the facility.
15. Keeping WSMC apprised of your current contact information.
16. Not videotaping or recording any WSMC staff.

1	Patient's Last Name	Patient's First Name	Date of Birth
2	<input type="checkbox"/> Please release information/send records FROM WSMC* <input type="checkbox"/> Please release records TO WSMC (To Person/Facility Below)                                  (From Person/Facility Below) *Transferring your primary care outside of WSMC may delay your appointment for specialty care.		
3	Full Name of Organization/Provider/Individual (or Self)		
	Address		City
	State	Zip	Phone # with area code      Fax with area code
	Transmit: Verbally <input type="checkbox"/> Electronic: <input type="checkbox"/> Fax <input type="checkbox"/> U.S. Mail: <input type="checkbox"/> CD <input type="checkbox"/> Paper		
4	CHOOSE ONLY ONE (1) Per Release ____Medical    ____HIV/AIDS Testing & Treatment    ____Alcohol/Substance/Drug Use Treatment ____Dental    ____Behavioral Health    ____ Psychotherapy Notes    ____Other:		
5	Time Frame: <input type="checkbox"/> Last Visit <input type="checkbox"/> Past Year <input type="checkbox"/> All <input type="checkbox"/> Other:		
6	<input type="checkbox"/> All records <input type="checkbox"/> Just these:		
7	Reason for release: <input type="checkbox"/> Personal <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Other:		
Authorization	By signing, I authorize use/disclosure of my health information and understand that:		
	<ul style="list-style-type: none"> <li>• I may revoke this authorization at any time by contacting WSMC in writing.</li> <li>• This authorization is valid for 1 year maximum or this earlier date: ____ / ____ / ____.</li> <li>• The recipient of your health information may not further disclose your information without obtaining another authorization from you.</li> <li>• All Alcohol &amp; Substance Abuse health information is protected and only releasable with a separate express written consent of the person it pertains to.</li> <li>• My treatment/eligibility of care is not based on this authorization.</li> <li>• This authorization is voluntary and a photocopy or fax of this authorization is as valid as the original</li> <li>• I have the right to a copy of this authorization.</li> </ul>		
SECTIONS 1-7 MUST BE COMPLETED TO BE VALID			
Signature _____ Date: ____ / ____ / ____ Tel: (____) ____ - _____			
If not patient: <input type="checkbox"/> Patient's Representative			
Print Name and State Relationship: _____			

RECEIVED BY:

PLEASE WRITE CLEARLY OR WE WILL NOT BE ABLE TO PROCESS THIS REQUEST.

Western Sierra Medical Clinic does not discriminate on the basis of race, color, national origin, sex, age or disability, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sexual orientation, or gender identity or expressions.