

Authorization for Release of Health Information



The Children's Clinic, PA
1003 West Meeting Street
Lancaster, SC 29720
Phone: (803) 289-5437
Fax: (803) 289-5440

I hereby authorize the use or disclosure of my identifiable health information as described below to the facility named above.

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

* * * * *

Information Released From: _____

* * * * *

Information Released To: _____

* * * * *

Information to be Released:

Entire Record Shot Record Lab Reports Other _____

Note: All records to be released unless otherwise specified.

Purpose of Records Release:

Changing Providers Legal or Insurance Review Disability Determination Other _____

Patient's Rights:

- I understand that I have a right to revoke this authorization at any time by notifying the organization listed above in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per The Children's Clinic, P.A. Privacy Practices/Policy.
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.

Signature of Parent/Guardian _____ Date _____

Relationship to Patient _____ Witness _____

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____

DATE COMPLETED _____

BIRTH DATE _____

AGE _____

M F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names and ages and where they live. _____

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the delivery Vaginal? Cesarean?

Was the baby born at term? _____ Early? _____ Late? _____

If cesarean, why? _____

If early, how many weeks' gestation? _____

Did your baby have any problems right after birth?

Did mother have any illness or problem with her pregnancy?
 Yes No Explain _____

Yes No Explain _____

During pregnancy, did mother
 Smoke Yes No Drink alcohol Yes No
 Use drugs or medications Yes No
 What _____ When _____

Was initial feeding Breast? Bottle?

Did your baby go home with mother from the hospital?
 Yes No Explain _____

General

- Do you consider your child to be in good health? Yes No Explain _____
- Does your child have any serious illness or medical condition? Yes No Explain _____
- Has your child had serious injuries or accidents? Yes No Explain _____
- Has your child had any surgery? Yes No Explain _____
- Has your child ever been hospitalized? Yes No Explain _____
- Is your child allergic to any medicines or drugs? Yes No Explain _____

Development

- Are you concerned about your child's physical development? Yes No Explain _____
- Are you concerned about your child's mental or emotional development? Yes No Explain _____
- Are you concerned about your child's attention span? Yes No Explain _____
- If your child is in school:
 How is his/her behavior in school? _____
 Has he/she failed or repeated a grade in school? _____
 How is he/she doing in academic subjects? _____
 Is he/she in special or resource classes? _____



Family History

Have any family members had the following:

- | | | | | |
|---|------------------------------|-----------------------------|-----------|----------------|
| Deafness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Heart disease (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High blood pressure (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bleeding disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Diabetes (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Epilepsy or convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Alcohol abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Drug abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental retardation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |

Additional family history _____

Past History

Does your child have, or has he/she ever had:

- | | | | |
|---|------------------------------|-----------------------------|---------------|
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Frequent ear infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with ears or hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with eyes or vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any heart problem or heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Anemia or bleeding problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Constipation requiring doctor visits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bladder or kidney infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bed-wetting (after 5 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| (For girls) Has she started her menstrual periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| (For girls) Are there problems with her periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any chronic or recurrent skin problem (acne, eczema, etc) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Convulsions or other neurologic problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Thyroid or other endocrine problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any other significant problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Use of alcohol or drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |