General Medical Records Release

Patient Name: _____

Address: _____

Phone: _____

SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of:

_____

to disclose/release all medical records to:

LifePoint Medical Consultants, LLC
Phone: (719) 314-9121

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I understand this authorization is voluntary and that I may refuse to sign this authorization.
By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or personal representative) Date

Medical Questionnaire

Birth Date:

Sex:

Family Health Physician (s):

Main Reason For your visit today: _____

Please list **Surgeries** (type of surgery and date). Include major **dental** work. _____

Please list all **Medications** _____

Please list **Accidents or Falls** (type and date) _____

Other Doctors you have seen for this condition

Any additional information or remarks _____

Other Information
Height _____ Weight (Now) _____ (One year ago) _____

Allergies

Exercise and sports

Life-style Habits