Camino Health Center

Patient Registration Form

Chart No: _____

Please answer all questions to the best of your ability. Your answers are confidential. Camino Health Center utilizes the information you provide to continuously evaluate existing programs and services. Additionally, Camino Health Center receives grant funding which requires the health center to provide statistics on its patient population. If you have any questions about this registration form, please ask a Patient Services Representative at the front desk for assistance.

PATIENT INFORMATION

SSN	Last Name	First Name	MI

Address	City	State	Zip Code

Home Phone ☐	Cell Phone ☐	Email Address
( )	( )	

Sex at Birth: ☐ Male ☐ Female

Date of Birth

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Are you employed? ☐ Full-Time ☐ Part-Time ☐ Self Employed ☐ Unemployed ☐ Retired ☐ Military

Are you a student? ☐ Full-Time ☐ Part-Time ☐ Not A Student

RESPONSIBLE PARTY/GUARANTOR (IF APPLICABLE)

Last Name	First Name	MI	Address	City	State	ZIP

Contact Phone Number ( )

Relationship To Patient: _____ **Preferred Language:** _____

EMERGENCY CONTACT (IF DIFFERENT FROM RESPONSIBLE PARTY)

Last Name	First Name	MI	Address	City	State	ZIP

Contact Phone Number ( )

Relationship To Patient: _____ **Preferred Language:** _____

Medical Insurance: I receive medical coverage from the following types of insurance:

Insurance Policy I.D.: _____

☐ Medicare ☐ Medi-Cal / CalOptima ☐ Covered California - Blue Shield PPO ☐ I am currently not receiving any insurance coverage

Race ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian (Hispanic/Latino) ☐ Other Multi-Racial

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Primary Language (Spoken & Written) /

Do you need an interpreter? ☐ Yes ☐ No

Are any members of your family migrant farm workers? ☐ Yes ☐ No

Are you a seasonal worker? ☐ Yes ☐ No

Are you homeless? ☐ Yes ☐ No

Housing Status ☐ Non-Homeless ☐ Transitional ☐ Street ☐ Unknown ☐ Homeless Shelter ☐ Doubling up ☐ Other

Are you a veteran? ☐ Yes ☐ No

Sexual Orientation ☐ Straight/Heterosexual ☐ Lesbian, Gay, or Homosexual ☐ Bisexual ☐ Something Else/Other ☐ Don't Know ☐ Choose Not To Disclose

Gender Identity ☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose Not To Disclose

Do you have any psychological, spiritual, or cultural values that will assist us in your treatment? ☐ Yes ☐ No

Do you have an Advance Health Care Directive? (Adults only) ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

Camino Health Center

Income Certification Form

Chart No: _____

Please answer all questions to the best of your ability. Your answers are confidential. Camino Health Center utilizes this information to determine if you qualify for a discount for your care. Not completing this documentation will make you ineligible to receive any discounts. This form is important to your health because it lets Camino be certain that you are receiving the very best service regardless of your income, family size, or insurance status.

Patient Name: _____ **Date of Birth** _____

1. Medical Insurance: I receive medical coverage from the following types of insurance:

- ☐ Medicare
- ☐ Medi-Cal / CalOptima
- ☐ Covered California - Blue Shield PPO
- ☐ I am currently not receiving any insurance coverage

Insurance Policy I.D. _____

2. Family Income: My family receives $ _____ every:

- ☐ Week (52)
- ☐ Two Weeks (26)
- ☐ Month (12)
- ☐ Year (1)

If no income:

- ☐ My family has no wages or income. I am not working (receiving salary or wages for work), or receiving unemployment or disability benefits. My income is $0.

3. Family Size: The number of family members in my household is: _____

By signing below, I certify that the above information is true and accurate and that I have reported all income. I acknowledge that I will be asked to verify my income on an annual basis and will provide proof of income if requested.

Signature of patient or legal guardian: _____ **Date:** _____

FOR STAFF USE ONLY

Calculate: $_____ (family income) X _____ (per year) = $_____ (annual income)

Enter annual income to calculate Sliding Fee Payment Amount: $ _____ per visit.

Comments:

_____

_____

_____

_____

Additional income documentation provided:

- ☐ Check Stubs
- ☐ Tax Forms (W2, Disability, SSI)
- ☐ Bank Statement
- ☐ Other: _____

☐ **PATIENT REFUSED TO SIGN CERTIFICATION OF INCOME FORM**

Staff Signature: _____ **Date:** _____

Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

NOTICE OF PRIVACY PRACTICES

Effective: July 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:

Privacy Officer
Camino Health Center
30300 Camino Capistrano
San Juan Capistrano, CA 92675
(949) 240-2030

WHO WILL FOLLOW THIS NOTICE

This notice describes Camino Health Center's practices and that of:

- Any health care professional authorized to enter information into your patient chart.
- All departments and units of Camino Health Center.
- Any member of a volunteer group we allow to help you while you are in Camino Health Center.
- All employees, staff and other Camino Health Center personnel.

These departments and units may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Camino Health Center. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Camino Health Center, whether made by Camino Health Center personnel or your medical provider. Other medical providers may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private (with certain exceptions);
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Camino Health Center personnel who are involved in taking care of you at Camino Health Center. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of Camino Health Center also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside of Camino Health Center who may be involved in your medical care after you leave Camino Health Center, such as skilled nursing facilities, home health agencies, and physicians or other practitioners. For example, we may give your physician specialist access to your health information to assist your physician in treating you.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive at Camino Health Center may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information about treatment you received at Camino Health Center to your health plan so it will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside of Camino Health Center who are involved in your care, to assist them in obtaining payment for services they provide to you. However, we cannot disclose information to your health plan for payment purposes if you ask us not to, and you pay for the services yourself.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Camino Health Center and make sure that all of our patients

receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Camino Health Center patients to decide what additional services Camino Health Center should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Camino Health Center personnel for review and learning purposes. We may also combine the medical information we have with medical information from other medical provider offices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

FUNDRAISING ACTIVITIES

We may use information about you, or disclose such information to a foundation related to Camino Health Center, to contact you in an effort to raise money for Camino Health Center and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

MARKETING AND SALE

Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

TO INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital.

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you arrive at the emergency department either unconscious or otherwise unable to communicate, we are required to attempt to contact someone we believe can make health care decisions for you (e.g., a family member or agent under a health care power of attorney).

AS REQUIRED BY LAW

We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS:

ORGAN AND TISSUE DONATION
We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS
If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

WORKERS' COMPENSATION
We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH ACTIVITIES
We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report regarding the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

HEALTH OVERSIGHT ACTIVITIES
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

LAWSUITS AND DISPUTES
If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

LAW ENFORCEMENT

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at Camino Health Center; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of Camino Health Center to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

INMATES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

MULTIDISCIPLINARY PERSONNEL TEAMS

We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF INFORMATION

In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information — e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information we maintain about you.

RIGHT TO INSPECT AND COPY

You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

To inspect and obtain a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Camino Health Center. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by Camino Health Center will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO AMEND

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Camino Health Center.

To request an amendment, your request must be made in writing and submitted to Camino Health Center's Chief Medical Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Camino Health Center;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations (as those functions are described above), and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to Camino Health Center. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you.

If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Camino Health Center's Privacy Officer. In your request, you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Camino Health Center. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website: http://www.caminohealthcenter.org/

To obtain a paper copy of this notice:

Attn: Medical Records
Camino Health Center
30300 Camino Capistrano
San Juan Capistrano, CA 92675

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Camino Health Center. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, to each time you register at Camino Health Center for treatment or health care services, you have the right to request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Camino Health Center or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Camino Health Center, contact:

Privacy Officer
Camino Health Center
30300 Camino Capistrano
San Juan Capistrano, CA 92675
(949) 240-2030

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the "Notice of Privacy Practices" of Camino Health Center. Our "Notice of Privacy Practices" tells you how we may use and disclose your protected health information. We encourage you to read it in full.

We may change our "Notice of Privacy Practices." If we change our notice, you may obtain a copy of the revised notice by contacting our organization at (949) 240-2272, Medical Records.

If you have any questions about our "Notice of Privacy Practices" please contact:

Privacy Officer
Camino Health Center
30300 Camino Capistrano
San Juan Capistrano, CA 92675
(949) 240-2030

I acknowledge receipt of the "Notice of Privacy Practices" of Camino Health Center.

Date:_____ Time:_____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

(over)

Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

Inability to Obtain Acknowledgement

Complete only if no signature is obtained. If it is not possible to obtain the individual's Acknowledgment, describe the good faith efforts made to obtain the individual's Acknowledgment, and the reasons why the Acknowledgment was not obtained.

Patient Name: _____

Reasons why the acknowledgment was not obtained:

- ☐ Patient refused to sign this Acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices.
- ☐ Other: _____

Date:_____ Time:_____ AM / PM

Signature: _____
(provider representative)

Print name: _____
(provider representative)

Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

Patient Chart #: _____

Authorization For Use or Disclosure of Protected Health Information

When you complete and sign this form, health information about you will be released as you describe and request in the form.

Section A: Patient Information (Required)

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Section B: Medical Records Request (Required)

☐ **I REQUEST that my medical records FROM the facility listed below be DISCLOSED and SENT to Camino Health Center via:**

- ☐ MAIL: Camino Health Center, Attn: Medical Records, 30300 Camino Capistrano, San Juan Capistrano, CA 92675
- ☐ FAX: (949) 240-5869, Attn: Medical Records
- ☐ I will pick up the records requested.

☐ **I AUTHORIZE Camino Health Center to DISCLOSE my medical information to the facility listed below via:**

- ☐ MAIL
- ☐ FAX
- ☐ I will pick up the records requested.

Name of Person/Medical Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ **I am requesting copies of my medical records for myself.**

- ☐ MAIL to: _____
- ☐ I will pick up the records requested.

Section C: Health Information to be Accessed or Disclosed (Required):

☐Complete Medical Record

OR the individual records marked below:

☐Discharge Summary ☐History & Physical ☐Progress Notes ☐Treatment Plan

☐Psychosocial Assessment ☐Emergency Room Record ☐Laboratory/Pathology Reports

☐Other (Specify): _____

Access or disclosure of medical information is limited to the following:

Type of information (Specific medical condition): _____

From (Date) _____ to (date) _____

Camino Health Center
Affiliated with Mission Hospital, St. Joseph Health

Patient Chart #: _____

Authorization For Use or Disclosure of Protected Health Information

****Specific Authorization to Release Sensitive Records****

I understand that this consent is to include disclosure of: (initial next to each)

_____HIV/AIDS Test Results _____Psychiatric/Mental Health _____Alcohol and/or Drug Abuse

_____Sexually Transmitted Disease Information

The purpose of the requested access or disclosure of records identified in SECTION C is for the following:

☐Patient Request

☐Other: _____

Section D: Individual Rights

1. You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed.
2. I understand that I may refuse to sign this authorization and that Camino Health Center may not condition my treatment upon whether I sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected.
3. I understand that this authorization is effective immediately and will remain in effect until _____ (Specify date, but no longer than six months from the date of this authorization).
4. I understand that I have a right to receive a copy of this authorization.
5. I reserve the right to withdraw or revoke this authorization, in writing at any time, except to the extent that Camino Health Center has already disclosed the information.
   To withdraw this authorization, submit written request to:

   Camino Health Center
   30300 Camino Capistrano
   San Juan Capistrano, CA 92675
   Tel: (949) 240-2272
   Fax: (949) 240-5869
6. There may be fees associated with copying and mailing of medical records.

Patient/Patient Representative Signature:_____Date: _____

If signed by other than patient, indicate relationship: _____

If interpreted: _____

Interpreter Signature Print Name Language

_____

Date Time Position/Relationship to Patient

CAMINO HEALTH CENTER USE ONLY

*Completed by:*_____*Date:* _____