Texas Spine Clinic™

NEW PATIENT INTAKE

Motor Vehicle Accident

Please complete every section as best you can. These details help us understand how you were injured and build the right treatment plan for you.

TODAY'S DATE _____

01 Patient Information

FULL NAME

DATE OF BIRTH

ADDRESS

AGE

CITY / STATE / ZIP

PREFERRED LANGUAGE

HOME PHONE

CELL PHONE

EMAIL ADDRESS

OCCUPATION

EMPLOYER

EMPLOYER PHONE

HEALTH INSURANCE COMPANY

POLICY HOLDER NAME

POLICY HOLDER DOB

POLICY HOLDER EMPLOYER

EMERGENCY CONTACT NAME

EMERGENCY CONTACT PHONE

FAMILY PHYSICIAN

PREFERRED PHARMACY & PHONE

SEX ◯ Male ◯ Female MARITAL STATUS S / M / D / W RACE / ETHNICITY ◯ Hispanic / Latino ◯ Non-Hispanic / Latino ◯ Decline to state

02 Auto Insurance & Claim Information

YOUR AUTO INSURANCE COMPANY

POLICY #

CLAIM #

ADJUSTER NAME & PHONE

OTHER DRIVER'S INSURANCE

OTHER DRIVER'S CLAIM #

ATTORNEY NAME / FIRM

ATTORNEY PHONE

Do you have Personal Injury Protection (PIP) or MedPay coverage? ☐ Yes ☐ No ☐ Not sure

Are you represented by an attorney for this accident? ☐ Yes ☐ No

Were you working or driving for your job at the time (possible Workers' Compensation)? ☐ Yes ☐ No

03 The Accident

DATE OF ACCIDENT

APPROX. TIME

CITY / STREET / INTERSECTION

1. Where were you in the vehicle?

○ Driver ○ Front-seat passenger ○ Rear-seat passenger

○ Pedestrian ○ Bicyclist ○ Motorcyclist

2. Type of collision (check all that apply)

☐ Rear-ended (hit from behind) ☐ I hit a vehicle in front ☐ Head-on

☐ T-bone — driver side ☐ T-bone — passenger side ☐ Sideswipe

☐ Rollover ☐ Hit a fixed object ☐ Multiple impacts

YOUR VEHICLE (YEAR / MAKE / MODEL)

YOUR EST. SPEED (MPH)

OTHER VEHICLE EST. SPEED (MPH)

3. Did you see the accident coming, or were you anticipating the impact? ☐ Yes ☐ No — it was a surprise

4. Did you brace yourself (grip the wheel, push on the brake or dash)? ☐ Yes ☐ No

5. At impact, was your head turned? ○ Facing forward ○ Left ○ Right ○ Not sure

6. Were you wearing a seatbelt? ○ Lap & shoulder ○ Lap only ○ No

7. Did you have any abrasions or bruising where the seatbelt was? ☐ Yes ☐ No

If yes, where (shoulder, chest, abdomen, hips)?

8. Did the airbags deploy? ☐ Yes ☐ No ☐ Not equipped

9. Did any part of your body strike the inside of the vehicle? (check all that apply)

☐ Head — steering wheel ☐ Head — windshield ☐ Head — side window / door

☐ Head — headrest ☐ Knee(s) — dashboard ☐ Chest — steering wheel

☐ Shoulder / arm — door ☐ Other ☐ Did not strike anything

10. Was there any loss of consciousness? ○ Yes ○ No ○ Not sure

If yes, for about how long? Do you remember the impact itself? ☐ Yes ☐ No

04 At the Scene

1. Were the police called to the scene? ☐ Yes ☐ No

Police department _____ Report / case # _____

2. Is your car drivable? ◯ Yes ◯ No — towed ◯ Declared a total loss

3. Approximate cost of damage to your vehicle

◯ Under $2,500 ◯ $2,500–$10,000 ◯ Over $10,000 ◯ Unknown

4. Were you able to get out of the vehicle on your own? ☐ Yes ☐ No

5. Were there other people in your vehicle? Were they injured? _____

05 Care After the Accident

1. Did you go to the emergency room or urgent care? ◯ ER ◯ Urgent care ◯ No

Facility name _____ Date seen _____

2. How did you get there?

◯ Ambulance ◯ Someone drove me ◯ Drove myself

3. What care did you receive there? (check all that apply)

☐ Examined only ☐ X-rays ☐ CT scan
☐ MRI ☐ Stitches ☐ Cervical collar
☐ Splint / cast / sling ☐ Medication given / prescribed ☐ Admitted to hospital

4. Were there any fractures (broken bones)? ◯ Yes ◯ No ◯ Not sure

If yes, which bone(s)? _____

5. Any cuts requiring stitches, burns, or other visible injuries? ☐ Yes ☐ No

6. When did you first notice pain?

◯ Immediately ◯ Within hours ◯ Next day ◯ Days later

7. Who else have you seen for this accident since? (check all that apply)

☐ Primary care doctor ☐ Urgent care ☐ Chiropractor
☐ Physical therapist ☐ Orthopedic specialist ☐ Neurologist
☐ Pain management ☐ Massage therapist ☐ No one yet

Provider names / imaging done since _____

06 Where Do You Hurt Since the Accident?

Check every area with pain or injury, mark the side, and rate the pain from 0 (none) to 10 (worst imaginable).

BODY AREA	LEFT	RIGHT	PAIN 0–10	NOTES
SPINE				
☐ Neck (cervical)	center / both			
☐ Upper / mid back (thoracic)	center / both			
☐ Lower back (lumbar)	center / both			
☐ Tailbone / sacral	center / both			
JOINTS & LIMBS				
☐ Shoulder	☐	☐		
☐ Elbow	☐	☐		
☐ Wrist / hand / fingers	☐	☐		
☐ Hip	☐	☐		
☐ Knee	☐	☐		
☐ Ankle / foot	☐	☐		
☐ Arm (upper / forearm)	☐	☐		
☐ Leg (thigh / calf)	☐	☐		
OTHER AREAS				
☐ Head / face	☐	☐		
☐ Jaw (TMJ)	☐	☐		
☐ Chest / ribs	☐	☐		
☐ Abdomen	☐	☐		
☐ Buttock	☐	☐		
Not listed: _____	☐	☐		
Not listed: _____	☐	☐		

07 Symptoms Since the Accident

CHECK ALL THAT APPLY

- ☐ Headaches
- ☐ Dizziness / vertigo
- ☐ Confusion or feeling “foggy”
- ☐ Memory problems
- ☐ Trouble concentrating
- ☐ Blurred / double vision
- ☐ Ringing in ears
- ☐ Sensitivity to light or noise
- ☐ Nausea

- [ ] Neck stiffness
- [ ] Pain radiating into arm / hand
- [ ] Pain radiating into buttock / leg
- [ ] Numbness / tingling in arm / hand
- [ ] Numbness / tingling in leg / foot
- [ ] Muscle weakness
- [ ] Muscle spasms
- [ ] Trouble sleeping
- [ ] Anxiety / fear of driving
- [ ] Nightmares or flashbacks
- [ ] Irritability / mood changes
- [ ] Fatigue

Pain character ☐ Dull ☐ Aching ☐ Sharp ☐ Stabbing ☐ Burning ☐ Electric / shooting ☐ Throbbing ☐ Stiff

Overall severity today ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Frequency ◯ Occasional (0–25%) ◯ Intermittent (25–50%) ◯ Frequent (50–75%) ◯ Constant (75–100%)

Since the accident, are your symptoms ◯ Better ◯ Same ◯ Worse

Any bowel or bladder changes since the accident? ☐ Yes ☐ No

WHAT MAKES PAIN WORSE? _____

WHAT MAKES PAIN BETTER? _____

08 Your Health Before the Accident

1. Before this accident, did you have pain or treatment in any of the same areas? ☐ Yes ☐ No

   If yes, which areas and what treatment? _____

2. Have you been in any previous motor vehicle accidents? ☐ Yes ☐ No

   If yes, year(s) and injuries _____

3. Had you ever been diagnosed with a spinal condition (herniated disc, stenosis, arthritis, etc.)? ☐ Yes ☐ No

   If yes, diagnosis _____

4. Any prior workplace, sports, or other injuries? ☐ Yes ☐ No

5. Before the accident, how would you rate your overall health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

09 Impact on Work & Daily Life

1. Have you missed work because of this accident? ☐ Yes ☐ No

   Days missed _____ Currently on light / modified duty? ☐ Yes ☐ No

2. Which activities are harder now than before the accident? (check all that apply)

- ☐ Driving
- ☐ Walking
- ☐ Bending
- ☐ Dressing / bathing
- ☐ Caring for children
- ☐ Sitting
- ☐ Sleeping
- ☐ Turning head
- ☐ Housework / yard work
- ☐ Working
- ☐ Standing
- ☐ Lifting / carrying
- ☐ Reaching overhead
- ☐ Exercise / sports
- ☐ Sexual activity

10 Past Medical History

CURRENT CONDITIONS — CHECK ALL THAT APPLY

- ☐ Hypertension
- ☐ DVT / blood clots
- ☐ Fibromyalgia
- ☐ Liver disease
- ☐ Diabetes
- ☐ Osteoporosis / osteopenia
- ☐ Depression / anxiety
- ☐ Cancer (specify below)
- ☐ Heart disease
- ☐ Rheumatoid arthritis
- ☐ Kidney disease
- ☐ Coagulation disorder

OTHER CONDITIONS / CANCER DETAILS

ALLERGIES (MEDICATIONS, CONTRAST DYE, IODINE, LATEX, ETC.)

ARE YOU PREGNANT OR COULD YOU BE PREGNANT?

☐ Yes ☐ No ☐ N/A

CURRENT MEDICATION	DOSE / FREQUENCY	STARTED AFTER ACCIDENT?
		Y / N
		Y / N
		Y / N
		Y / N
		Y / N

PREVIOUS SURGERY / PROCEDURE	YEAR

11 Family & Social History

HEALTH PROBLEMS IN FAMILY MEMBERS (SPINAL DISEASE, ARTHRITIS, OSTEOPOROSIS, CANCER, HEART DISEASE, DIABETES, ETC.)

Cigarettes / tobacco	☐ Yes ☐ No		
Alcohol	☐ Yes ☐ No	If yes, how much per week	_____
Exercise regularly	☐ Yes ☐ No	If yes, type / frequency	_____

12 Review of Systems

Check any symptoms you are currently experiencing. Check "None of the above" if no symptoms in that category.

ALLERGIC / IMMUNOLOGIC

- ☐ Cancer
- ☐ Seasonal allergies
- ☐ Immune deficiency
- ☐ None of the above

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ SOB on exertion
- ☐ Edema / swelling
- ☐ Heart murmurs
- ☐ None of the above

ENDOCRINE

- ☐ Excess thirst
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Frequent urination
- ☐ Excessive hunger
- ☐ Goiter
- ☐ None of the above

EAR / NOSE / THROAT

- ☐ Nosebleed
- ☐ Hoarseness
- ☐ Sinusitis
- ☐ Hearing difficulty
- ☐ Thyroid mass
- ☐ Neck stiffness
- ☐ None of the above

GASTROINTESTINAL

- ☐ Loss of appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Nausea / vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ None of the above

CONSTITUTIONAL

- ☐ Weight loss / gain
- ☐ Fever
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ None of the above

GENITOURINARY

- ☐ Urgency / frequency
- ☐ Burning urination
- ☐ Blood in urine
- ☐ Bladder incontinence
- ☐ Recurring infection
- ☐ None of the above

HEAD / EYES

- ☐ Headache
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Vision changes
- ☐ Double vision
- ☐ Eye pain
- ☐ Head injury
- ☐ None of the above

HEMATOLOGIC / LYMPHATIC

- ☐ Easy bruising
- ☐ Blood clots
- ☐ Lymphedema
- ☐ Easy bleeding
- ☐ Swollen glands
- ☐ Blood transfusion
- ☐ None of the above

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ None of the above

NEUROLOGICAL

- ☐ Seizures
- ☐ Paralysis
- ☐ Tremors
- ☐ Numbness / tingling
- ☐ Memory loss
- ☐ Balance difficulty
- ☐ None of the above

PSYCHIATRIC / RESPIRATORY

- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts
- ☐ SOB / wheezing
- ☐ Cough
- ☐ Night sweats
- ☐ None of the above

13 Authorization & Signature

I have read the above information and certify it to be true and correct to the best of my knowledge. I hereby authorize Texas Spine Clinic to perform any necessary examinations and/or treatment in accordance with Texas statutes and laws.

I authorize Texas Spine Clinic to release medical records and billing related to this accident to my auto insurance carrier and/or attorney listed above, as needed to process my claim.

PATIENT SIGNATURE _____ DATE _____

GUARDIAN SIGNATURE (IF APPLICABLE) _____ DATE _____

FOR OFFICE USE ONLY

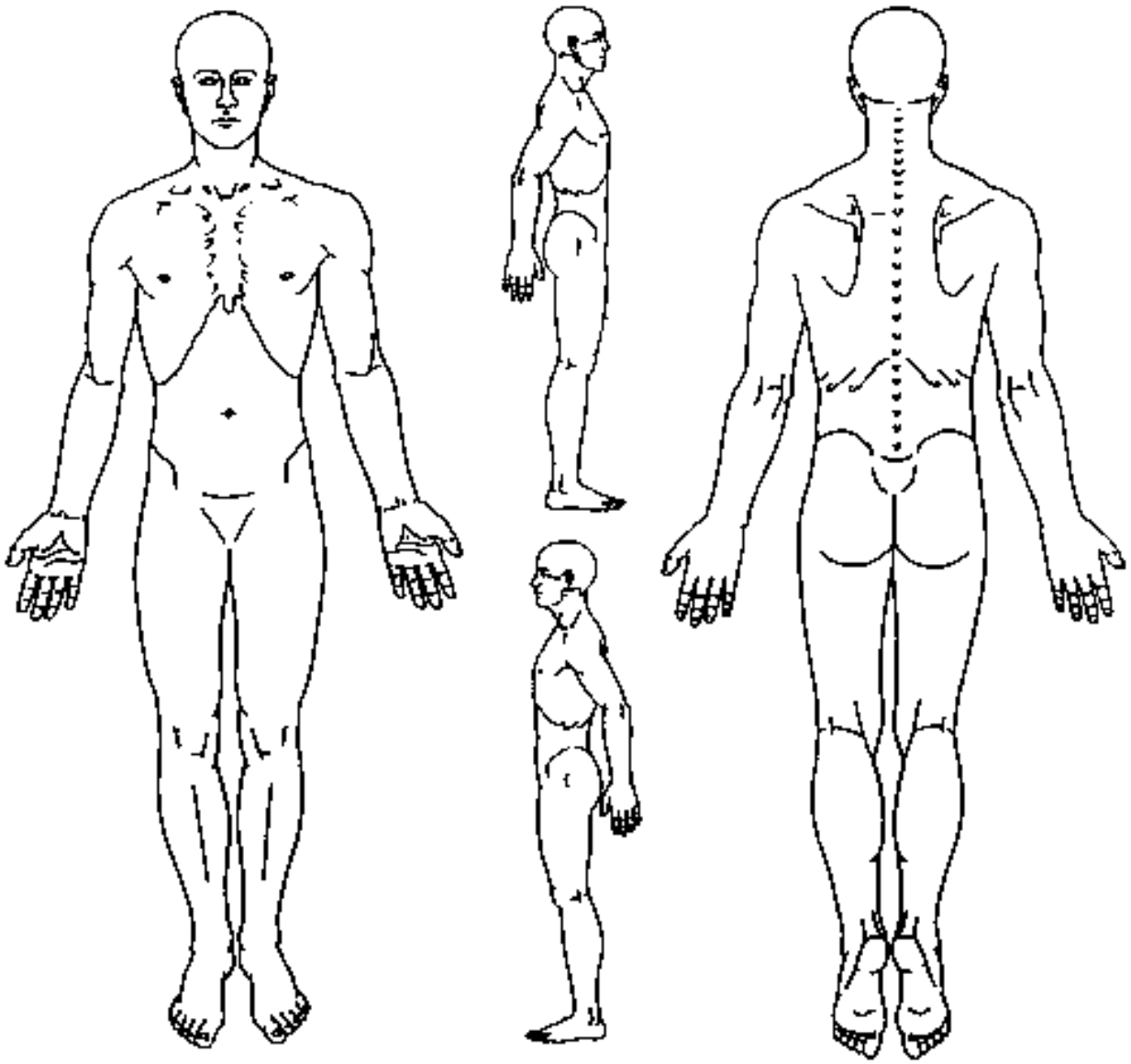
Received by	Date verified	Claim verified	PIP / MedPay limit
Attorney LOP on file	**Police report on file**	**Records requested**	**Case type**

THE REVISED OSWESTRY PAIN QUESTIONNAIRE

NAME _____ DATE _____

How long have you had back pain _____ years _____ months _____ weeks

On the diagram below, please indicate where you are experiencing pain, right now. Please complete both sides of this form.



A = ACHE	**B** = BURNING	**N** = NUMBNESS
P = PINS & NEEDLES	**S** = STABBING	**O** = OTHER

Please Read: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity

A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care

A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increase the pain, but I manage not to change my way of doing it.
D. Washing and dressing increase the pain and I it necessary to change my way of doing it.
E. Because of the pain, I am unable to do any washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3--Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g. on the table.
E. Pain prevents me from lifting heavy weights , but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 --Walking

A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than one mile.
D. Pain prevents me from walking more than 1/2 mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5--Sitting

A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than 1/2 hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 -- Standing

A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I can't stand for more than 10 minutes without increasing pain.
F. I avoid standing because it increases pain right away.

SECTION 7--Sleeping

A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping.
C. Because of pain , my normal night's sleep is reduced by less than one-quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8--Social Life

A. My social life is normal and gives me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. Pain prevents me from sleeping at all.

SECTION 9--Traveling

A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms off travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10--Changing Degree of Pain

A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

DISABILITY INDEX SCORE: %_____

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but Please **just circle the one choice which closely describes your problem *right now*.**

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come in-frequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all all.

SIGNATURE:_____ **DATE:**_____

DISABILITY INDEX SCORE: **%**_____

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, the Texas Spine Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that the Texas Spine Clinic is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Texas Spine Clinic reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Texas Spine Clinic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Who may we share your information regarding ☐Medical information ☐ Billing/Payment information?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including but not limited to disclosures via fax, email, telephone, and by mail.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient's Signature Date

Patient Information:

Full Name: _____

Address: _____

Date of Birth: _____ Soc. Sec. # _____

Medical Records Release

Facility Information is Requested From

_____
_____
_____

Requesting Organization

Texas Spine Clinic
3212 NAPIER PARK
SAN ANTONIO, TX 78231

Date and Type of Information Requested

_____/_____/_____ _____

_____/_____/_____ _____

_____/_____/_____ _____

I, _____, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1.) I do hereby authorize Texas Spine Clinic to obtain and release the following types of medical information: MRI/CT/Radiograph reports, History/Physical examination reports, Progress reports, Surgical reports and/or any information that could be relevant to my medical condition.
2.) I have the right to revoke this authorization at any time by writing to the health care provider listed. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3.) I understand that signing this authorization in voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be condition upon my authorization of this disclosure.
4.) Information disclosed under this authorization may be subject to redisclosure by the recipient.
5.) Date of authorization and expiration _____/_____/_____ thru _____/_____/_____

_____ _____

Patient Signature *Date*