Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

To All New Patients:

Welcome and thank you for choosing Primary Care Clinic to be your primary care physician. Our goal is to make your first visit as pleasant and informative as possible.

Please review and complete attached new patient forms. After review and completion of the forms please return to us with a copy of your insurance card(s) via email (drtan.primarycare@gmail.com) fax (615-771-8551) or mail to above address at least 48 hours prior to your scheduled appointment. Failure to do so will result in your appointment having to be rescheduled. This policy allows us to get your information entered into our system prior to your arrival and prevents unnecessary wait time for you**. Please Note: You must contact us 48 hours in advance if you are unable to keep your New Patient appointment. Failure to cancel or re-schedule your appointment will result in a No Show fee of $30.00**

Bring your insurance card(s) and driver's license (or any government issued ID) along with a list of all of your prescription and over-the-counter medications with you to your appointment. If you are unable to provide us with your insurance card(s), your appointment will need to be rescheduled.

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We will strive to stay on time. From time to time, a patient emergency arises and we may be running late for your visit. You will have the option to re-schedule or stay and be seen.

You will be asked to fill out new registration forms annually so we may update your information.

If you have any questions or need to reschedule this appointment, please call our office. We do require 48-hours' notice if you are unable to keep a scheduled appointment. Thank you for choosing Primary Care Clinic to help with your health care needs.

Sincerely,
Primary Care Clinic, LLC

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: 615) 771-8551 E: drtan.primarycare@gmail.com

Patient Registration Form

Patient Information

Last Name:	First Name:	M.I.	Previous Name:
Mailing Address:		Apt #:	
City/State/Zip:			
Home Phone:	**Cell Phone:** *Can we leave a message regarding your medical care & test results?* ***Y*** ***N***		**Work Phone:**
Date of Birth:	Sex: ☐ Male ☐ Female	Family Physician:	
Marital Status:	Social Security #:		
Employer Name:	Emergency Contact Name:		
Emergency Contact Phone #:	Relationship to Patient:		

Additional Information and Responsible Party

Person responsible for the bill (ONLY IF DIFFERENT THAN THE PATIENT):

Last Name:	First Name:	
Date of Birth:	SSN #:	Phone:
Address of Person Responsible (if different from patient):		
City/State/Zip:	Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL FIELDS BELOW):

Email Address:	**Can we leave a message regarding your medical care & test results?** ☐ **Yes** ☐ **No**
Race (please select): ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Black or African American ☐ Other ☐ Decline	**Ethnicity (please select one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language (please select one): ☐ English ☐ Bosnian ☐ Indian (including Hindi & Tamil) ☐ Russian ☐ Sign Language ☐ Spanish ☐ Other

Preferred Pharmacy Location:

Insurance Information

Primary Policy Holder Information (ONLY IF DIFFERENT THAN THE PATIENT OR RESPONSIBLE PARTY):

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Relationship to Patient:	Policy Holder Relationship to Patient:
Policy Holder Address:	Policy Holder Address:

I have read and agree to Primary Primary Care Clinic (PCC) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PCC all money to which I am entitled for medical expenses related to the services performed from time to time by PCC, but not to exceed my indebtedness to PCC. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to PCC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Primary Care Clinic's Privacy Notice. ☐ **(Initials)**

Signature of Responsible Party: _____ Date_____

Printed Name of Responsible Party:_____

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: 615) 771-8551 E: drtan.primarycare@gmail.com

Name: _____ Date of Birth: ___/___/ 19___ Age: ____ Sex: ____
How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Review of Systems ♦

Please review the following symptoms and circle those items that are a problem for you

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

❑ ***Place an "X" in the box to the left if you have none of the above.***

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	
COVID-19 Vaccine					

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

FINANCIAL POLICY AND DISCLOSURE

PLEASE INITIAL SIGN AND DATE

Primary Care Clinic, LLC is committed to excellent patient care. The following guidelines will provide you with specific information regarding our financial policies. We believe that your understanding of these policies is important to our professional relationship.

Insurance. We participate in most insurance plans, including Medicare. ***If you are not insured by a plan we accept, payment in full is expected at each visit.*** If we do accept your plan, but you do not have a current insurance card, payment in full for each visit is required until we verify coverage. **Knowing your insurance benefit plan is your responsibility.** It is your responsibility to make sure the correct in- network facility is used for all test and hospital encounters, including lab work. Please contact your insurance company with any questions you may have regarding your coverage prior to receiving the service. **Initial: _____**

Co-payments. ***All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company.*** Failure to collect co-payments and deductibles from patients is against the law. Please help us in upholding the law by paying your co-payment at each visit.

Self-Pay. If you are a self-pay patient, you will be required to pay for the office visit before services are rendered. In addition, any remaining balance on your account will be collected at discharge. **Initial: _____**

Payment. We accept payment by cash, credit and debit card. All previous balances must be paid at time of service, unless prior arrangements have been made with the billing department. If a check is returned for insufficient funds or payment has been stopped, you will be charged a $30 fee in addition to the amount of the check. You will also be asked to pay by cash, credit or debit card for future visits. **Initial: _____**

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. **In order to submit claims, we must have the patient's date of birth, social security number and a copy of your photo identification. In addition, we must obtain the policyholders date of birth and social security number in order to file claims with your insurance carrier.** Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. **Initial: _____**

Nonpayment / Overdue Balances. If your account becomes delinquent, you agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection fees. After you have received a statement, your account is considered past due. Payment plans are available but must be negotiated with the billing dept. prior to your account being sent to collections. You must contact us for a reasonable payment arrangement or risk collection action. **Initial: _____**

Missed Appointments: Appointments are in high demand and your early cancellation will give another patient the opportunity to be seen. If you do not show up for your appointment and you do not cancel the appointment **48 hours** in advance, you will be assessed a NO SHOW fee of $35.00. This fee will be your responsibility and must be paid prior to your next visit. This policy allows us to make better use of our available appointments for those patients in need of medical care. **Initial: _____**
Please note: Three (3) "missed scheduled appointments" may result in discharge from the practice.

Worker's Compensation. If you are injured on the job, please let the receptionist know so we may contact your employer to facilitate filing your claim. If you are covered under worker's compensation, we will accept the payments by your work comp carrier as per the contracted rates. If payment is denied from your worker's compensation carrier, you will be responsible for the balance in full. Payment will be due ten {10) days following any worker 's compensation denial.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. If you have any questions, please feel free to discuss with the front desk staff or the billing department. Please do not discuss financial aspects with the physician(s).

Responsible Party Signature: _____ Date: _____

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

NARCOTIC POLICY

NOTICE TO ALL PATIENTS

Dr. Jean L. Tan does not prescribed narcotics for chronic pain. It is her policy to refer patients with this condition to pain management experts.

I, _____ have read and understand the above narcotic policy of Primary Care Clinic and Dr. Jean L. Tan, MD.

_____ _____

Patient Signature **Date**

PHARMACY

We send all prescription electronically; please list your pharmacy of choice.

Name: _____

Address: _____

Phone: _____

Notice of Privacy Practices for Primary Care Clinic, LLC

(Referred to herein as the "Clinic")

This Notice is first in effect on April 14, 2003.

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

1. The *Clinic* is permitted to make uses and disclosures of protected health information for treatment, payment and health care operations, as described in the following examples:

    a. For treatment – The nurse obtains treatment information about you and records in chart. The physician may need to consult another specialist regarding your care and treatment and share your information.

    b. For payment – Our office staff will relay information to your health insurance payor to obtain payment for the services provided to you here at the *Clinic* and in the hospital.

    c. For health care operations – Periodic reviews by *Clinic* staff of both your clinical and your financial information will be conducted to monitor for accuracy, safety and appropriateness.

2. The *Clinic* is permitted or required, under specific circumstances, to use or disclose protected health information without the Patient's written authorization. In addition to disclosures for treatment, payment and operations, the *Clinic* may be required to make disclosures for purposes of workers' compensation, public health, law enforcement or similar state or federal laws or ordinances.

3. Other uses and disclosures will be made only with the Patient's written authorization, and the Patient may revoke such authorization.

4. The *Clinic* may contact the Patient to provide appointment reminders or information about treatment alternatives or other heath-related benefits and services that may be of interest to the Patient or patient.

5. The Patient has the following rights regarding protected health information:

    a. The right to request restrictions on certain uses and disclosures of protected health information. **The *Clinic* is not required to agree to a requested restriction, however.**

    b. The right to receive confidential communications of protected health information, as applicable.

    c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.

    d. The right to amend protected health information, as provided in the Privacy Regulation.

    e. The right to receive an accounting of disclosures of protected health information.

    f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to a Patient who has agreed to receive the Notice electronically.

6. The *Clinic* is required by law to maintain the privacy of protected health information and to provide Patients with notice of its legal duties and Privacy practices with respect to protected health information.

7. The *Clinic* is required to abide by the terms of the Notice currently in effect.

8. The *Clinic* reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that the *Clinic* maintains.

9. The *Clinic* will provide Patients or patients with a revised Notice by providing copies of the revised Notice at the *Clinic's* front desk.

10. Patients may complain to the *Clinic* and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the *Clinic*, if they believe their privacy rights have been violated. A brief description of how the Patient may file a complaint is as follows: Direct a written copy of the facts and allegations of your complaint to the attention of the **HIPAA Privacy Officer** at the address below or you may telephone the **HIPAA Privacy Officer,** Jean L. Tan, MD directly at **615-771-8549,** 125 Cool Springs Blvd, Ste 230, Franklin, TN 37067 or to Office of Civil Rights, US Dept. of Health and Human Services, 200 Independence Ave, SW, Room 509F, HHH Bldg, Washington, DC 20201.

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

Medication History Consent Form

By signing below, I give permission for **Primary Care Clinic, LLC** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Primary Care Clinic, LLC** to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____

Patient Name (Print)

_____ _____

Patient Signature Date

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

How the Secure Patient Portal Works:

A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Print name: _____ DOB: _____

Patient Signature: _____ Date: _____

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years.

Name of Parent/Guardian requesting access:

_____

Last Name Middle Initial First Name

_____

Relationship to the Patient Date

Our Patient Portal site may be accessed by two different URL's.

Our Website: www.jeantanmd.com

Patient Portal direct site: https://mycw9.eclinicalweb.com/portal72/jsp/100mp/login.jsp

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

Patient Portal Authorization Form

Purpose of this Form:

The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results from staff to patient
- Request prescription refills
- View your medical summary, medication list, treatment history and visitation dates
- Re ceive reminders through your email
- View current and past statements

The following will **NOT** be accepted through Patient Portal:

- Receiving advice on the best course of treatment for your medical problem. All diagnosis will be made by your provider when your are seen for an office visit.
- Request for narcotics/controlled medications.
- Request for refill for medication not currently being prescribed by our Provider

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 10 failed log in attempts before the account is locked
- You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails.
- You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
- If you forget your password you may request another one through Patient Portal by clicking on the "Forgot Password" link.
- After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
- Our hours of operation are 8:30 am - 5:00 pm Monday-Tuesday-Wednesday-Friday. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- We reserve the right to suspend or terminate the patient portal at any time and for any reason.

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

PERSONAL REPRESENTATIVE DESIGNATION

Authorized Use and/or Disclosure

I authorize **Primary Care Clinic** to release Personal Health Information to the person(s) named as my Personal Representative for the purpose of assisting with, or facilitating, the coordination of medical health care information or payment of my health plan benefits. I also understand that if my Personal Representative is not a health care provider or other person subject to federal privacy laws, my Personal Health Information may no longer be protected by those privacy laws and may be subject to re-disclosure by my Personal Representative. **Primary Care Clinic** is not responsible should my Personal Representative further disclose my protected Personal Health Information. I further understand that I have the right to limit the information that you release under this authorization.

Designation of Personal Representatives(s)

Name of Authorized Person:	Relationship to Patient:	SS#: Optional
Name of Authorized Person:	Relationship to Patient:	SS#: Optional
Name of Authorized Person:	Relationship to Patient:	SS#: Optional

(If there is no representative, please leave it blank)

_____

Signature of Patient/Legal Representative Date

_____

Printed Name of Legal Representative Description of Legal Representative to Patient

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

Patient Name: _____ DOB: _____

WHAT IS A PREVENTIVE EXAM?

Also called a "Physical", "Wellness Exam" or "Annual Exam"

A preventive exam is a scheduled medical evaluation of an individual that focuses on preventive care. It includes an age and gender appropriate history, an examination, a review of risk factors & plans to reduce them and the ordering of appropriate immunizations, screening laboratory tests, ultrasound or diagnostic procedures.

What does this mean?

A preventive exam is a periodic exam that covers all prevention and health maintenance issues related to age, sex and family history; it is a "Well Exam". A preventive exam is not a follow-up visit or a problem based visit. A preventive exam cannot be expected to deal with everything that has been bothering you since your last visit.

A SECOND Service May Be Necessary

If time allows and dependent on the judgment of the provider, new problems or chronic disease follow-up issues may be addressed as a SECOND service during this visit. Examples of chronic issues are endometriosis, pcos, vulvodynia, abnormal bleeding, etc.....

NOTE: YOUR insurance plan may require co-pay or apply charges to your deductible for a **SECOND** service provided during a Preventive Exam visit. Please consult with your insurer or HR department to understand your insurance coverage requirements. Patient Signature: Patient Name:

Patient Signature: _____ Date: _____

Primary Care Clinic, LLC

125 Cool Springs Boulevard, Suite 230, Franklin, TN 37067
T: (615) 771-8549 F: (615) 771-8551 E: drtan.primarycare@gmail.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION

Name (Print) _____ DOB _____ SSN _____

INFORMATION TO BE RELEASED FROM

Name of Facility or Provider: _____

Address: _____

Tel. No: _____ Fax No.: _____

INFORMATION TO BE SENT TO

Name of Designated Recipient: Primary Care Clinic, LLC / Dr. Jean L. Tan
Address: 125 Cool Springs Blvd., Suite 230, Franklin, TN 37067
Tel. No.: 615-771-8549 Fax No.: 615-771-8551

INFORMATION TO BE RELEASED (Please check one)

_____ The most recent 2 years of pertinent information (chart notes, labs, x-rays and special tests)
_____ All medical records
_____ Specific information (please specify): _____

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE (please check one)

_____ Attorney _____ Insurance _____ Doctor _____ Personal

PATIENT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (place initial)

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

MY RIGHTS

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature _____ Date _____
(Patient, Guardian or Authorized Representative)