AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: ____ Date of Birth: __________________________

Social Security: ____ Phone: ______________________________

Persons/organizations providing the information:

Name: ____

Address: ____

City, State, Zip: ____

Organizations receiving the information:

Williamson Medical Group

4323 Carothers Parkway, Suite 505

Franklin, TN 37067 Fax: 615-435-7352

What is the purpose of the use or disclosure? **At the request of the Individual**

Section B: Must be completed only if the healthcare provider has requested the authorization

1. Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ____ Yes _X_ No
2. Information to be disclosed: The information to be disclosed includes only those items checked below, with respect to services provided on or around NEXT APPOINTMENT DATE.

☐ Entire Medical Record	☐ Lab/Pathology results	☐ HIV/AIDS test results
☐ Discharge summary	☐ Diagnostic reports	☐ Alcohol/Drug treatment
☐ History and physical exam	☐ ER visit	☐ Other (specify): ____________

Section C: Must be completed for all authorizations

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the physician declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by sending a written notice to the Medical Group. However, the revocation will not have any effect on any uses or disclosures the Medical Group may have made before the revocation was received. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed. I understand that I may refuse to sign this Authorization and that the Medical Group will not condition treatment on whether I sign this Authorization.

I certify that I am:

☐ The patient and the identification that I provided is true and correct.

☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.
My relationship to the patient is that of: ____________________________________

Signature: ________________________________ ______________________
Date

Print Name: ________________________________

WMG USE ONLY:

Date Received:	
How was identity verified:	Copy Made? ☐ Yes ☐ No
How was authority verified:	Copy Made? ☐ Yes ☐ No
Completed by: Date:	

PATIENT PERMISSION FORM

I, ____, give Williamson Medical Group permission to (please check all that apply):

Call my:
- ☐ Home Phone ____________________________
- ☐ Cell Phone ____________________________
- ☐ Work Phone ____________________________

Leave a message on my:
- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone

Regarding:
- ☐ Appointments
- ☐ Medical Conditions
- ☐ Lab work, test results, etc.

May discuss my medical condition with:

____

____

____

____

Other preferences: ____

Patient or Legal Guardian’s Signature: ____ Date: ______________

PATIENT INFORMATION/SLEEP HISTORY FORM

FAX: (615) 435-7729

____
NAME: LAST FIRST MIDDLE SS#

____
ADDRESS: STREET CITY STATE/ZIP CODE

____
PHONE: HOME OTHER DATE OF BIRTH AGE

HEIGHT ________ WEIGHT _______ SEX: ______ MARITAL STATUS ____________________

EMERGENCY CONTACT(S)

____
NAME PHONE RELATIONSHIP

____
NAME PHONE RELATIONSHIP

EMPLOYER/OCCUPATION ____

INSURANCE CO. ______________________________________ INS. POLICY # ____________________________

IF APPLICABLE: MEDICARE # ___________________________ MEDICAID # ____________________________

____
REFERRING PHYSICIAN PHONE

____
ADDRESS: STREET CITY STATE/ZIP CODE

____
FAMILY PHYSICIAN PHONE

NAME OF PERSON COMPLETING QUESTIONNAIRE, IF OTHER THAN THE PATIENT

____
NAME PHONE RELATIONSHIP
****

CHIEF COMPLAINTS: What are your major complaints related to sleep & wakefulness and how long have you had them?

____

____

____

I. SLEEPINESS

	YES	NO
1. Are you excessively sleepy during the day?	☐	☐
2. Do you fall asleep or have to fight sleep while		
a. Sitting quietly	☐	☐
b. Driving	☐	☐
c. Riding	☐	☐
d. Talking	☐	☐
e. Eating	☐	☐
f. Standing	☐	☐
g. Talking on the phone	☐	☐
3. Do you take scheduled naps during the day?	☐	☐

II. SYMPTOMS DURING SLEEP

1. Circle any of the following symptoms that you currently have when sleeping or trying to sleep.

Toss & Turn	Fall out of bed	Bed wetting	Nightmares
Heartburn	Sour belches	Pain	Irresistible urge to move legs
Regurgitation	Night sweats	Teeth grinding	Leg jerking
Cold feet	Sleep walking	Sleep talking	

2. Circle any of the following that you experience during sleep.

Choking	Making whistling sounds	Gasping for air	Waking yourself with snoring
Loud snoring	Struggling to breathe	Stop breathing	Sleeping with mouth open
Snorting	Waking up with dry mouth		

3. Do you snore in all positions? _______ in not, when? ____

III. SLEEP HABITS

1. What time do you usually go to bed? ____

2. How long does it usually take you to fall alseep? ____

3. How many times do you awaken at night? ____

4. Why do you awaken at night? ____

5. Do you have trouble returning to sleep? ____

SLEEP HABITS CONTINUED

6. What time do you usually wake in the morning? ______________________________
7. How do you wake up in the morning? (alarm clock, ect.) __________________________
8. What time do you usually get up in the morning? _____________________________
9. Do you usually sleep longer when you don't have to get up? If so, How long? _____________
10. How many hours of actual sleep time do you think you get each night on average? __________
11. Upon awakening in the morning, do you feel: **Completely Rested or Partially Rested or Not Rested at All**
12. Do you frequently have 2 headache during the night or in the morning?
13. Do you take anything to help you sleep? ___________________ What? __________________

IV. NARCOLEPSY

	YES	NO
1. As you fall asleep or wake up, do you have vivid lifelike visions?	☐	☐
2. When you are angry or excited, do you have sudden weakness or have any part of your body to go limp?	☐	☐
3. As you are trying to go to sleep or wake up, do you ever have an inability to move?	☐	☐
4. Have you ever driven or traveled somewhere and did not remember how you got there?	☐	☐

V.TREATMENT

Have you ever been treated for your sleep problems? If so, explain: ___________________________

____

IV. PSYCHOLOGICAL

Circle any of the following symptoms that you have to an excessive degree:

Fatigue	Inability to concentrate	Memory impairment	Family problems
Anxiety	Depression	Irritability	Loss of appetite
Suicidal thoughts	Change in personality		

VII. SEXUALITY

	YES	NO
1. Is your sex drive normal?	☐	☐
2. Men: 2) Are your erections normal?	☐	☐
b) Do you sometimes have erections when you wake up in the morning?	☐	☐

VIII. WEIGHT

1. What do you weigh now? ______________________________
2. How long have you weighed this amount? ______________________________
3. What did you weigh one year ago? ______________________________

IX. MEDICAL HISTORY

I. Do you have high blood pressure? ______________________________

2. Have you ever had a problem with or surgery on your tonsils, adenoids, nose or throat? ______________
____

3. Do you have a thyroid condition? ____________ If so, what? ______________________

4. List any chronic medical conditions that you have.

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

5. List any surgery or injuries that you have had.

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

6. List any drugs to which you are allergic.

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

7. List any drugs that you take regularly. Include over the counter medications, hormones, birth control pills, etc.

1. ______________________ 2. ______________________
3. ______________________ 4. ______________________
5. ______________________ 6. ______________________

8. When was your last complete physical examination? ______________ By whom? ______________
9. Did you have blood work done? ______________________________
10. Have you had thyroid function studies? ______________________________

X. SOCIAL AND FAMILY HISTORY

1. Do you smoke? _________ How long? ______________________________________
   Did you previously smoke? _______ How long?______________________________________
2. Do you drink alcohol? _______ How long? ______________________________________
3. How much coffee or tea do you drink? ____
4. What do you usually do at work? ____
5. What are your working hours? ________________________ So you rotate shifts? ____________
6. How many people live in your home? _____________ Relationship to you: __________________
   ____
7. How many bedrooms do you have? ____
8. Does any of your family members have a sleep problem or snore loudly? ____________________

XI. REVIEW OF SYMPTOMS

Do you have any of the following? (circle)

Sore throat	Dry throat	Sinus trouble
Cough	Wheezing	Chest pain
Shortness of breath	Heartburn	Indigestion
Sour belches	Swelling legs	Frequent urination

Please list any other symptoms or problems that you may have that are not covered above.
Elaborate on any symptoms indicated above if necessary.

____
____
____
____
____

M.D. Signature: ______________________________ Reviewing M.D. Signature: ___________________________