WELCOME TO OUR PRACTICE

We are happy you have chosen MAHEC Family Health Centers for your care!

We are a group practice offering care for the entire family where patients of all ages can establish their care. We are a primary care medical home, meaning our team of healthcare professionals work together to provide all of your healthcare needs. You, the patient, are the most important part of a patient-centered medical home. We strive to provide evidence-based care in a professional, supportive atmosphere. Our providers look forward to an on-going relationship with you and an exceptional patient experience at every appointment.

Our full-spectrum family healthcare services include

- Primary care for children, adults and older patients
- Family-centered obstetrics including lactation consultation for breastfeeding support
- Sports medicine
- Family therapy and individual counseling
- Free interpreter services
- Geriatric medicine
- Hep C/HIV treatment
- Positive parenting program (Triple P)
- Integrated clinical pharmacy support, laboratory services and X-Rays
- Medication for opioid use disorder and substance abuse recovery support
- No-scalpel vasectomies and other procedures
- Nutritional counseling with registered dietitians including pediatric healthy weight medical visits
- DOT / CDL physicals
- IDD clinical care
Welcome to MAHEC!

Thank you for choosing us for your healthcare. MAHEC has been a part of Asheville since 1974 and we proudly continue our tradition of award-winning care. Our providers and staff welcome the opportunity to care for your entire family at our Family Health Centers, Internal Medicine office, OB/GYN offices, Dental offices and Center for Psychiatry. We proudly serve all patients regardless of income or insurance status.

- MAHEC is expanding our financial assistance program to go above and beyond what we have offered before. In order to facilitate this change we are asking all existing and new patients to complete a new patient information packet.
- Our Patient Financial Advocates are available to guide you through signing up for assistance offered through our Sliding Scale Discount Program. Eligibility is based on family income and family size. Payment is expected at time of service for amounts you are responsible for. We can assist with payment options if you are unable to pay in full.

BEFORE YOUR VISIT

This welcome packet includes forms you need to read and complete before your visit.

It is VERY important that you fill out each form completely and give the entire packet to the front desk staff when you arrive for your appointment. Please arrive 15 minutes before you appointment to complete the check-in process.

Other documentation you need to bring with you:
- Insurance card and driver’s license (or other valid photo ID)
- Pertinent medical history or records
- Current List of medications or medication bottles
  - Drug name
  - Prescribed dosage(s)
  - How long you have been taking the drug(s)

MAHEC’s Patient Portal

We are pleased to provide all patients with an online tool that provides 24/7 access to your personal health record. With the portal, you can securely email your provider, see lab results, review your medical records and much more. We will use the email address you provide to give you access to the portal if you don't currently have it. Just watch for an email with instructions that will come to you after your appointment.

Thank you for choosing us for your healthcare!

Mountain Area Health Education Center
www.mahec.net
MAHEC Patient Registration Form

Please complete the following information using black ink. THIS INFORMATION IS CONFIDENTIAL.

- Internal Medicine
- FHC Biltmore
- FHC Cane Creek
- FHC Enka/Candler
- FHC Newbridge
- Ob/Gyn Biltmore
- Ob/Gyn Franklin
- Women’s Care Brevard
- Psychiatry
- Deerfield
- Givens

PATIENT INFORMATION

Name: _______________________________ Date of Birth: _______________________________
Home Address: _______________________________ Birth Sex: ☐ Male ☐ Female
City: __________________ State: _______ ZIP: __________ SS#: __________________________
Home County: ___________________ Email Address: _______________________________
Home Phone: ___________________ Cell Phone: ______________________________ Work Phone: __________________

By providing a phone number, mobile phone number, or email address, I authorize MAHEC to contact me or my guardian/legal representative to remind me of appointments, to obtain feedback on my experience at this office, and to provide general health reminders and other information regarding my healthcare.

Gender Identity:
☐ Male
☐ Female
☐ Transgender Male
☐ Transgender Female
☐ Other
☐ Choose not to disclose

Sexual Orientation:
☐ Lesbian or Gay
☐ Heterosexual (or straight)
☐ Bisexual
☐ Something else
☐ Don’t know
☐ Choose not to disclose

Preferred Language:
☐ English
☐ Spanish
☐ Russian
☐ American Sign Language
☐ Other: ____________________________

EMERGENCY CONTACT INFORMATION

Name: _______________________________
Relationship: _________________________ Phone#: _______________________________

IF PATIENT IS CHILD (UNDER 18)

Responsible Party Name: _______________________________
Relationship: _________________________ Phone#: _______________________________

June 2021 | Page 1 of 3
I hereby authorize payment of all insurance, Medicaid, and/or Medicare benefits directly to MAHEC and I authorize them to file insurance on my behalf. I also authorize them to release medical and/or account information to my insurance, Medicaid, and/or Medicare carrier as required to satisfy claims. I agree to notify them should my coverage change.

I understand that MAHEC:

- Expects payment on the date of service (if insured, co pays and deductibles are expected on the date of service).
- Accepts cash, checks, debit cards or major credit cards.
- Expects Medicaid, Medicare and all insurance will be filed for me. However, it is my responsibility to know the details of my insurance coverage and provide MAHEC with current and accurate information.
- Will work with me to establish payment plans.
- Provides services and treatment, which are medically appropriate. However, some of these may not be covered by my insurance plan and these will be my responsibility to pay.
- Expects my insurance company to pay within 90 days from the date of service and will bill me directly if the insurance does not pay.
- Expects the parent or guardian to pay for all services rendered to their dependents.
- Expects me to keep appointments and to call at least 24 hours prior, if I need to cancel. I understand that failure to do this may result in being discharged from the practice.

I have read and understand the above.

Patient or Parent/Guardian Signature: ___________________________ Date: ___________________________

Note: Failure to sign does not relieve you of the above expectations.
CONSENT FOR TREATMENT

I voluntarily consent to routine services, medical treatment(s), diagnostic radiology procedure(s), diagnostic lab(s), behavioral health services, and services offered by lay health workers (e.g. doula, community health worker, peer support specialist) as deemed necessary by the healthcare providers treating me at any MAHEC facility. I voluntarily consent to allow MAHEC to seek emergency medical care from a physician or hospital, if needed. I understand that diagnostic procedures may include but are not limited to lab tests on blood, urine, and tissue, including drug screenings. I understand that diagnostic radiology procedures include but are not limited to x-ray, ultrasound, and/or mammography. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I understand I have the right to ask questions about my treatment and/or procedures and the right to refuse any treatment or procedure. I agree to notify my provider of my concerns.

Patient or Parent/Guardian Signature: _____________________________ Date: _____________________________

ALTERNATIVE CONTACT AUTHORIZATION

I authorize MAHEC to discuss medical and financial information concerning the care and services provided to me with the individuals listed below:

Contact #1
Name: _____________________________
Relationship: _____________________________ Phone#: _____________________________

Contact #2
Name: _____________________________
Relationship: _____________________________ Phone#: _____________________________

Contact #3
Name: _____________________________
Relationship: _____________________________ Phone#: _____________________________

NOTICE OF PRIVACY ACKNOWLEDGMENT

I have been given the opportunity to read MAHEC’s Notice of Privacy Practices, and my questions concerning the Notice have been answered. I understand if I choose not to sign this acknowledgment, MAHEC will continue to provide services to me and will use and disclose my Protected Health Information (PHI) in accordance with MAHEC’s Notice of Privacy Practices.

Patient or Parent/Guardian Signature: _____________________________ Date: _____________________________
New Patient Intake Form

Patient Name: ___________________________ Date of Birth: ______________

Form Completed by: ___________________________ Date of Today’s Visit: ______________

Have you received medical care from another physician in the last 5 years? □ Yes □ No If yes, please give name and location.

Physician name: ___________________________

Physician city and state: ___________________________

What is the reason for your visit today? ___________________________

ALLERGIES
Do you have any allergies or bad reactions to medicines, foods or latex? □ Yes □ No If yes, please list them below.

Medicine, food, latex or other substance: ___________________________

Reaction caused: ___________________________

MEDICATIONS
Please list ALL medications you currently take (including birth control pills, vitamins, supplements and herbs) even if you do not take them every day, and even if they are over the counter.

Name of medication, vitamin, herb or supplement: ___________________________

Dosage (ex: how many mg or tablets you take): ___________________________

How often you take it: ___________________________

Are you taking a multivitamin with folic acid? □ Yes □ No

Local Pharmacy: ___________________________ Mail Order: ___________________________

MEDICAL HISTORY
Have you ever had any the following? Please check the boxes of all that apply to you.

□ Alcohol abuse □ COPD/Emphysema □ Cancer, other: ____________ □ History of physical abuse □ Thyroid trouble

□ Anemia □ Depression □ COPD/Emphysema □ History of sexual abuse □ Other:

□ Anxiety □ Diabetes □ Heart attack, when: ____________ □ Irritable Bowel Syndrome □ Kidney disease

□ Arthritis □ Drug Abuse □ Heart failure □ Kidney stones □ Migraines

□ Asthma □ GERD/Reflux □ Hepatitis, choose: □ A □ B □ C □ Migraines □ Osteoporosis

□ Attention Deficit Disorder □ Heart attack, when: ____________ □ High blood pressure □ Seizures □ Sexually Transmitted Disease

□ Bipolar Disorder □ Heart failure □ High cholesterol □ Skin cancer, when: ____________ □ Stroke

□ Bladder problems □ Hepatitis, choose: □ A □ B □ C □ Thyroid trouble

□ Blood clots □ Kidney stones □ High blood pressure □ Alcohol abuse

□ Breast cancer, when: ____________ □ Kidney stones □ High cholesterol □ Alcohol abuse

□ Colorectal cancer, when: ____________ □ Liver disease □ High blood pressure □ Alcohol abuse
**SURGICAL HISTORY**

What surgeries or procedures have you had? Please check the boxes of all that apply to you.

- [ ] Amputation
  - Where: ____________________________ Year: ________
- [ ] Appendectomy
- [ ] Artificial joints
  - Where: ____________________________ Year: ________
- [ ] Back surgery
  - Year: ________
- [ ] Breast surgery  [ ] Left  [ ] Right
  - Year: ________
- [ ] Cataract extraction  [ ] Left  [ ] Right
  - Year: ________
- [ ] Catheterization of heart
  - Year: ________
- [ ] Gall bladder removed
  - Year: ________
- [ ] Heart surgery
  - Year: ________
- [ ] Hernia repair  [ ] Left  [ ] Right
  - Year: ________
- [ ] Knee surgery  [ ] Left  [ ] Right
  - Year: ________
- [ ] Neck surgery
  - Year: ________
- [ ] Ovaries removed  [ ] Left  [ ] Right
  - Year: ________
- [ ] Stress test of heart
  - Year: ________
- [ ] Tonsils removed
  - Year: ________
- [ ] Tubes tied
  - Year: ________
- [ ] Uterus removed
  - Year: ________
- [ ] Vasectomy
  - Year: ________

Description of surgery or any other surgeries you have had: ____________________________________________

**REPRODUCTIVE HISTORY**

How many pregnancies have you had? ______  Number of live births: ______  Number of living children: ______

Number of C-Sections: ______  Number of miscarriages: ______  Number of still births: ______  Number of abortions: ______

Menopause (‘change of life’) since: ____________

**IMMUNIZATION HISTORY**

Are your childhood vaccinations up to date?  [ ] Yes  [ ] No  [ ] Unsure  Have you had the following vaccines?

- [ ] Flu (this year)  [ ] Yes  [ ] No  Date: ________
- [ ] Pertussis (“whooping cough”)  [ ] Yes  [ ] No  Date: ________
- [ ] Shingles  [ ] Yes  [ ] No  Date: ________
- [ ] Tetanus  [ ] Yes  [ ] No  Date: ________
- [ ] COVID  [ ] Yes  [ ] No  Brand: ____________ Date: ________

Others: ____________________________  [ ] Yes  [ ] No  Date: ________

**FAMILY MEDICAL HISTORY**

Please indicate if your mother (m), father (f), sister (sis), brother (b), daughter (d), son (son) has a history of the following.

- [ ] Alcohol abuse  Who? ________  [ ] High blood pressure  Who? ________
- [ ] Asthma  Who? ________  [ ] Lung problems  Who? ________
- [ ] Cancer, other: ____________________________  Who? ________  [ ] Other mental illness  Who? ________
- [ ] Depression  Who? ________  [ ] Prostate cancer, how old: ____________  Who? ________
- [ ] Eczema  Who? ________  [ ] Thyroid trouble  Who? ________
- [ ] Heart attack, how old: ____________  Who? ________  [ ] Other: ____________________________  Who? ________

If your father is deceased, how old was he when he died? ______  What did he die from? ____________________________

If your mother is deceased, how old was she when she died? ______  What did she die from? ____________________________

July 2021
Patient Name: ____________________________________________ Date of Birth: ____________________________

SOCIAL HISTORY
Please indicate your marital or relationship status.
☐ Single  ☐ Married since: ____________________________
☐ Not married, living together since: _______________________  
☐ Separated since: __________  
☐ Divorced since: __________  
☐ Widowed since: __________  
What is your gender identity? ____________________________

SEXUAL HISTORY
Are you sexually active?  ☐ Yes  ☐ No
What is the gender of your sexual partner(s)? ________________
Age you became sexually active: ____________________________
Number of sexual partners in the last year: ____________________  
What is your sexual orientation? ____________________________

ALCOHOL & DRUG USE
On average, how many alcoholic beverages do you drink per week? __________________________

Men under 65:
How many times in the past year have you had 5 or more drinks in a day?  
☐ None  ☐ 1 or more  
How many times in the past year have you had 4 or more drinks in a day?  
☐ None  ☐ 1 or more

Women (and men over 65):
How many times in the past year have you had 4 or more drinks in a day?  
☐ None  ☐ 1 or more

How many times in the past year have you used a recreational drug or a prescription medication for non-medical reasons?  
☐ None  ☐ 1 or more

TOBACCO USE
☐ I have never used tobacco
☐ I have smoked, started at age: ______
☐ I still smoke ____ packs per day
☐ I quit _______ (date) but used to smoke ____ packs per day
☐ I have tried to quit _____ times
☐ I chew or use smokeless tobacco
☐ I vape or use e-cigarettes
☐ I am exposed to second-hand smoke

The following people make up my household.

Name: ____________________________ Year born: _______ Relation to me: __________________
Name: ____________________________ Year born: _______ Relation to me: __________________
Name: ____________________________ Year born: _______ Relation to me: __________________
Name: ____________________________ Year born: _______ Relation to me: __________________
Name: ____________________________ Year born: _______ Relation to me: __________________
Name: ____________________________ Year born: _______ Relation to me: __________________
Patient Name: ___________________________  Date of Birth: ___________________________

**REPRODUCTIVE LIFE PLANNING**
Would you like to become pregnant in the next year?  
☐ Yes  ☐ No  ☐ Okay either way  ☐ Unsure
Are you using any method to prevent pregnancy?  
☐ Yes  ☐ No
If yes, what: _____________________________
Do you use condoms?  ☐ Yes  ☐ No

**WOMEN'S HEALTH**
Have you ever had an abnormal pap test?  ☐ Yes  ☐ No
When was your last pap? _____________________________
Was it normal?  ☐ Yes  ☐ No
When was your last mammogram? _____________________________
Was it normal?  ☐ Yes  ☐ No
When was your last bone density (DEXA) scan? _____________________________
Was it normal?  ☐ Yes  ☐ No

**COLORECTAL HEALTH**
Date of most recent colonoscopy: _____________________________
Date of other colorectal cancer screening: _____________________________

**ADVANCED CARE PLANNING**
Have you filled out forms to indicate your desires for end of life care?  
☐ Yes  ☐ No  ☐ Okay either way  ☐ Unsure
Durable power of attorney for healthcare (“DPOA”):  ☐ Yes  ☐ No
If yes, who: _____________________________
Living Will:  ☐ Yes  ☐ No

**COMPREHENSIVE REVIEW OF SYSTEMS**
Please check the boxes of any symptoms you have had in the past 2 weeks.

**General**
☐ Fatigue  
☐ Fever  
☐ Loss of appetite  
☐ Unplanned weight gain  
☐ Unplanned weight loss

**Skin**
☐ New sore or lesion  
☐ Non-healing sores  
☐ Rashes

**Eyes/Ears/Nose/Throat/Mouth**
☐ Began wearing glasses or contacts  
☐ Change in vision  
☐ Bad teeth  
☐ Dentures  
☐ Frequent stuffy nose  
☐ Hearing loss  
☐ Hoarseness  
☐ Nose bleeds  
☐ Ringing in ears  
☐ Seasonal allergies  
☐ Sinus pain  
☐ Snoring

**Lungs**
☐ Breathing problems  
☐ Cough  
☐ Coughing up blood  
☐ Wheezing

**Breasts**
☐ Breast lump  
☐ Breast pain

**Cardiovascular**
☐ Chest pain or pressure  
☐ Heart beats fast  
☐ Heart skips  
☐ Short of breath with exercise  
☐ Short of breath lying down  
☐ Waking at night short of breath  
☐ Swelling or edema

**Gastrointestinal, continued**
☐ Difficulty swallowing  
☐ Heartburn  
☐ Nausea  
☐ Vomiting

**Genitourinary**
☐ Bleeding after menopause  
☐ Blood in urine  
☐ Difficulty holding urine  
☐ Difficulty urinating  
☐ Excessive urination at night  
☐ Pain or burning with urination  
☐ Sexual health concerns  
☐ Trouble with periods

**Muscles and Skeleton**
☐ Backache  
☐ Muscle pain  
☐ Painful joints

**Endocrine**
☐ Excessive thirst  
☐ Hot flashes

**Neurological**
☐ Fainting or passing out  
☐ Headaches  
☐ Memory loss  
☐ Numbness or tingling  
☐ Sense of room spinning  
☐ Tremor  
☐ Unsteadiness or imbalance  
☐ Weakness

**Mental Health**
☐ Change in sleep pattern  
☐ Feeling nervous, anxious or on edge

**Blood**
☐ Easy bleeding  
☐ Easy bruising  
☐ Swollen glands

**Other:** _____________________________

**DEPRESSION SCREENING (PHQ-2)**
Over the past two weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things:</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
<tr>
<td>Feeling down, depressed or hopeless:</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
</tr>
</tbody>
</table>

July 2021
SLIDING SCALE DISCOUNT PROGRAM
Compassionate financial support

Thank you for applying to our Sliding Scale Discount Program!

These documents will need to be turned in before your application can be processed:
• Completed Application
• Proof of Income

Please return all documents to your Patient Financial Advocate within 30 days of your first appointment.

Family Health Centers and Internal Medicine
Financial Advocate
Phone: (828) 771-3507
Fax: (828) 407-2640

Mailing Address:
123 Hendersonville Rd
Asheville, NC  28803

Ob/Gyn Specialists
Financial Advocate
Phone: (828) 771-5443
Fax: (828) 407-2639

Mailing Address:
119 Hendersonville Rd
Asheville, NC  28803

Center for Psychiatry and Mental Wellness
Financial Advocate
Phone: (828) 771-3460
Fax: (828) 820-8327

Mailing Address:
125 Hendersonville Rd
Asheville, NC  28803

Dental Health Centers
Financial Advocate
Phone: (828) 398-5918
Fax: (828) 552-8691

Mailing Address:
123 Hendersonville Rd
Asheville, NC  28803

If you have any questions regarding this program, please feel free to contact your Patient Financial Advocate at the numbers listed above.

Thank You!
Sliding Scale Discount Program

Compassionate financial support

Sliding Fee Discount Application

It is the policy of MAHEC to provide essential services for Medical, Behavioral Health, and Dental Care regardless of the patient’s ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all essential services provided and billable by MAHEC. Services performed by outside organizations and equipment that is purchased from outside companies, including outside laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services, will not be covered under this policy. This form must be completed every 12 months or if your financial situation changes.

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATE OF BIRTH</th>
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</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>STREET ADDRESS</th>
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</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
<th>PHONE</th>
</tr>
</thead>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list spouse and dependents

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
<th>Needs Sliding Scale</th>
<th>Current MAHEC patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes    No</td>
<td>Yes      No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes    No</td>
<td>Yes      No</td>
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<td></td>
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<td>Yes    No</td>
<td>Yes      No</td>
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<td>Yes      No</td>
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<td>Yes    No</td>
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<td>Yes    No</td>
<td>Yes      No</td>
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<tr>
<td></td>
<td></td>
<td>Yes    No</td>
<td>Yes      No</td>
</tr>
</tbody>
</table>
### Annual Household Income for all working adults

<table>
<thead>
<tr>
<th>Source</th>
<th>Self</th>
<th>Spouse</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last two pay stubs, tax form with schedule C if you are self-employed, or letter from employer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other other miscellaneous sources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Copies of tax returns, pay stubs, or other information verifying income are required before a discount is approved.

I certify that the family size and income information shown above is correct.

Name (please print) ______________________________________________________ Date ____________

Signature _________________________________________________________________________________

---

**Office Use Only**

Approved by: ____________________________________________________________________________ Date approved: ____________________________________________________________________________

Family size: ___________________________________________________________________________

Income: _______________________________________________________________________________

Approved discount: _____________________________________________________________________ Date received signed agreement: _______________________________________________________________________

---

**Verification Check List**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification/Address: Driver’s license, utility bill, employment ID, or</td>
<td></td>
</tr>
<tr>
<td>Income: Prior year tax return, two most recent pay stubs, or other</td>
<td></td>
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</tbody>
</table>

March 12, 2021
**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**COMPLETE ALL SECTIONS, DATE, AND SIGN**

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth:</th>
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</tbody>
</table>

I authorize the use or disclosure of the above named individual’s health information as described below.

<table>
<thead>
<tr>
<th>The information is to be disclosed by:</th>
<th>And is to be provided to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NAME OF FACILITY:</strong></td>
<td>Family Health Center at:</td>
</tr>
<tr>
<td></td>
<td>☐ Biltmore ☐ Newbridge ☐ Deerfield</td>
</tr>
<tr>
<td></td>
<td>☐ Cane Creek ☐ Enka/Candler ☐ Givens</td>
</tr>
<tr>
<td><strong>ADDRESS:</strong></td>
<td>123 Hendersonville Road</td>
</tr>
<tr>
<td><strong>CITY/STATE:</strong></td>
<td>Asheville, NC 28803</td>
</tr>
<tr>
<td><strong>PHONE #:</strong></td>
<td><strong>FAX #:</strong></td>
</tr>
</tbody>
</table>

**The purpose or need for this disclosure is:**

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol (including records of a program that provides alcohol or drug abuse diagnosis, treatment, or referral, as defined by federal law at 42 CFR Part 2), rape, abuse (sexual, physical, elder, spousal, etc.) abortion, sexual diseases like HIV/AIDS and other communicable disease and genetic testing.

**Information to be disclosed:** *(check appropriate box(es))*

- [ ] Standard release (last 3 years of notes, lab/x-ray reports, med list, allergy list, immunization record, consult notes.)
- [ ] Only information related to *(specify)*: _____________________________________________________________________
- [ ] Only the period of events from: _______________________________ to __________________________________
- [ ] Entire medical record
- [ ] Exclusions __ AIDS/HIV test results, diagnosis, treatment, and related information
  - [ ] Drug screen results and information about drug and alcohol use and treatments
  - [ ] Mental health notes
  - [ ] Genetics testing

I understand that this authorization will expire 90 days from the date it is signed unless I have specified a different expiration date or expiration event as follows. ____________________________________________________________

I understand that I may cancel this authorization at any time by notifying in writing the MAHEC Privacy Officer, 121 Hendersonville Road Asheville, NC 28803, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that MAHEC will not condition treatment or eligibility for care on the provision of this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

**By signing below, I acknowledge that I have read and understand this Authorization.**

<table>
<thead>
<tr>
<th>SIGNATURE OF PATIENT</th>
<th>DATE</th>
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<tbody>
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<table>
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<tr>
<th>SIGNATURE OF AUTHORIZED REPRESENTATIVE PATIENT, IF APPLICABLE <em>(State relationship to Patient)</em></th>
<th>DATE</th>
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<thead>
<tr>
<th>WITNESS TO SIGNATURE, IF APPLICABLE</th>
<th>DATE</th>
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</table>

**YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.**