SPACE COAST HEALTH CENTERS INC.
A Florida not-for-profit corporation

Patient _____

DOB _____

Athena Pt ID _____

Date _____

If you need help filling out these forms, please let us know.
Please have Photo ID, Social Security Card, and Insurance Card ready for staff.

PATIENT INFORMATION

Patient Last Name _____ First Name _____ Middle _____

Mailing Address _____ City _____ State _____ Zip _____

Phone # _____ Social Security # _____ DOB _____ Age _____

Email Address _____ Primary Language _____ Marital Status _____

EMERGENCY CONTACT

In Case of Emergency Contact (other than spouse) Phone # _____

Contact Last Name _____ First Name _____ Middle _____

Mailing Address _____ City _____ State _____ Zip _____

EMPLOYER INFORMATION

Patient's Employer _____ Phone # _____

Employer's Address _____ City _____ State _____ Zip _____

Occupation _____

PARENT/SPOUSE INFORMATION

Parent/Spouse Last Name _____ First Name _____ Middle _____

DOB _____ Social Security # _____ Phone # _____

GUARANTOR INFORMATION

Person Responsible for Payment (other than Insurance Company)

Relation to Patient _____ Phone # _____

Guarantor Last Name _____ First Name _____ Middle _____

Mailing Address _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance Company _____

Subscriber Last Name _____ First Name _____ Middle _____

DOB _____ Policy # _____ Group # _____

Secondary Insurance Company _____

Subscriber Last Name _____ First Name _____ Middle _____

DOB _____ Policy # _____ Group # _____

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FINANCIAL INFORMATION

Family Size _____ Total Annual Gross Income (per year) _____

Agricultural Worker	☐ Yes	☐ No	☐ Choose Not to Disclose
Homeless Status	☐ Yes	☐ No	☐ Choose Not to Disclose
School-based Health Center Patient	☐ Yes	☐ No	☐ Choose Not to Disclose
Veteran Status	☐ Yes	☐ No	☐ Choose Not to Disclose
Public Housing Patient	☐ Yes	☐ No	☐ Choose Not to Disclose

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PATIENT CONSENTS AND ACKNOWLEDGMENTS

Consent for Treatment (Self)

I authorize the healthcare providers of Space Coast Health Centers (SCHC) to treat, prescribe medications and consent to photograph for purposes of treatment and accurate identification for me, as the providers feel necessary.

Initial Here

Consent for Treatment of another Patient/Minor (Not Self)

I, as the parent or legal guardian/representative of the patient, do hereby give my consent and authorize treatment. Furthermore, the named individuals below may, if I am not present, in accordance with the consent communicated by the above individual to Physicians pursuant to the delegation of my authority granted here, and consistent with the Providers' professional judgment of my Child's medical needs, authorize Providers to see, examine, evaluate and treat (including immunizations, minor procedures and/or lab work).

Authorized Persons to Consent for Treatment of another Patient/Minor

Last Name _____ First Name _____ Middle _____

Relationship _____ Phone # _____

Last Name _____ First Name _____ Middle _____

Relationship _____ Phone # _____

Initial Here

Insurance Authorization

I authorize the release of any information concerning my healthcare, advice, and treatment, for the purposes of evaluation and administration of claims for insurance benefits processing. I permit a copy of this authorization to be used in place of the original. I hereby authorize payment of insurance benefits directly to Space Coast Health Centers. I understand this is a lifetime authorization.

Initial Here

Students Working On Site

I understand that SCHC supports the education of medical professionals and has students that may assist in relation to care.

Initial Here

Notice of Privacy Practices

I acknowledge I have received SCHC's Privacy Notice which describes the ways SCHC may use and disclose my healthcare information for its treatment and payment/healthcare operations and other described and permitted uses and disclosures. I understand I may contact the CEO if I have questions or a complaint. To the extent permitted by the law, I consent to the use and disclosure of my information for the purposes described in SCHC's Privacy Notice.

Initial Here

Patient Rights and Responsibilities

I acknowledge I have received a copy of my Rights and Responsibilities and I understand all my rights and responsibilities and agree to comply with the requirements of SCHC.

Initial Here

HIPAA Consent

We are unable to give out confidential patient information to any party over the telephone or in person without your written authorization. If you wish us to discuss your medical information over the telephone or in person with someone other than yourself, we ask that you complete the authorization below.

I authorize SCHC to release my Protected Health Information (PHI) to the authorized person or persons listed below. This may include information relating to sexual transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDs), and infection with the human immunodeficiency virus (HIV). It may also include information about the behavioral or mental health services and treatment for drug or alcohol abuse.

Last Name _____ First Name _____ Middle _____

Relationship _____ Phone # _____

Last Name _____ First Name _____ Middle _____

Relationship _____ Phone # _____

Is it OK to leave results or a message on your phone? ☐ Yes ☐ No

Initial Here

(Continued on the following page)

SPACE COAST HEALTH CENTERS INC.
A Florida not-for-profit corporation

Patient _____

DOB _____

Athena Pt ID _____

Date _____

PATIENT CONSENTS AND ACKNOWLEDGMENTS (Continued)

Notice of Policy regarding Advanced Directives (for Patients over 18 years old)

Advanced Directives are legal statements that indicate the type of medical treatment wanted, or not wanted, in the event an individual is unable to make decisions, as well as who is authorized to make them.

Advanced Directives are made and witnessed prior to serious injury. In accordance with federal and state law, this serves as notification that we will set aside your Advanced Directive in the event you experience a life-threatening event while at one of the SCHC locations and you will be transferred to a higher level of care.

By signing below, you agree and understand this as notification. Please indicate below whether you have an Advanced Directive.

☐ I have an Advanced Directive	☐ I do not have an Advanced Directive
☐ I have a Living Will	☐ I do not have a Living Will
☐ I have a Healthcare Surrogate	☐ I do not have a Healthcare Surrogate
☐ I have a Durable Power of Attorney	☐ I do not have a Durable Power of Attorney

Initial Here

Appointment Cancellations

To assist the patient in keeping appointments, our staff makes appointment reminder calls to each patient on the day prior to the appointment.

To assure that patients have access to care when needed by maximizing the utilization of available appointments, failure to cancel an appointment without 24-hour advance notice is considered a No Show.

Patients who have three (3) No Show cancellations without the appropriate 24-hour advance notice will be reviewed by the CMO and may be dismissed from the center. A letter of dismissal will be sent certified mail to the patient and a copy maintained in the patient's chart.

Initial Here

Patient Name (Print) _____

Patient Signature _____ Date _____

SPACE COAST HEALTH CENTERS INC.
A Florida not-for-profit corporation

Patient _____

DOB _____

Athena Pt ID _____

Date _____

HEALTH HISTORY

Patient Last Name _____ First Name _____ Middle _____

Primary Doctor's Name _____

Referring Doctor's Name _____

Pharmacy and Location _____

Please check the box below if you or an immediate family member have/have had any of the following conditions.
Please include details about the condition.

CONDITION	YOU	YOU, DESCRIBE	FAMILY	YOUR FAMILY, DESCRIBE
Asthma				
Autoimmune Disorder				
Bleeding Disorder				
Blood Clots				
Depression/Mental Health				
Diabetes				
Eating Disorder				
Gastrointestinal				
Glaucoma				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Liver Disease or Hepatitis				
Neurological Disorder				
Phlebitis				
Pneumonia				
Rheumatic Fever				
Thyroid Disease				
Tuberculosis				
Varicose Veins				

Any other information/conditions you feel should be a part of your medical record? _____

_____

_____

Have you ever had a blood transfusion? If yes, describe _____

_____

_____

SPACE COAST HEALTH CENTERS INC.
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DOB _____

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Date _____

ALLERGIES/MEDICATIONS/SURGERIES/HOSPITALIZATIONS

Patient Last Name _____ First Name _____ Middle _____

ALLERGIES—LATEX/ADHESIVES

Are you allergic to Latex? ☐ Yes ☐ No

Are you allergic to Adhesives? ☐ Yes ☐ No

ALLERGIES—MEDICATIONS/SUBSTANCE

MEDICATION/SUBSTANCE NAME	REACTION

MEDICATIONS

Please list any medications you are currently taking (prescriptions, supplements, over-the-counter, homeopathic).

MEDICATION	STRENGTH/DOSE	HOW OFTEN	PRESCRIBING DOCTOR	LAST TAKEN

SURGERIES/HOSPITALIZATIONS

Please list any surgical procedures and/or hospitalizations.

DATE	REASON FOR ADMISSION	PROCEDURE/TREATMENT	HOSPITAL/LOCATION

SPACE COAST HEALTH CENTERS INC.
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DOB _____

Athena Pt ID _____

Date _____

IMMUNIZATION/GENETIC HISTORY

Patient Last Name _____ First Name _____ Middle _____

IMMUNIZATION HISTORY

Please check Yes or No

Did you attend public school in the United States?	☐ Yes	☐ No
Did you received routine vaccines as a child?	☐ Yes	☐ No
Have you received hepatitis B vaccine series (3 vaccines)?	☐ Yes	☐ No
Have you had a flu shot this year?	☐ Yes	☐ No
Have you had chickenpox?	☐ Yes	☐ No
If you have not had chickenpox, have you had the chickenpox vaccine?	☐ Yes	☐ No
Have you had a tetanus shot in the last 10 years?	☐ Yes	☐ No
Have you had vaccinations to travel outside of the U.S.?	☐ Yes	☐ No

If yes, please list _____

_____

GENETIC HISTORY

Please check Yes or No for the following conditions. This pertains to yourself, the father of your baby and immediate family members. If you answer Yes to any of the following, please describe.

35 Years or Older	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No
Neural Tube Defect (Spina Bifida, Meningomyecele, Anencephaly)	☐ Yes	☐ No
Congenital Heart Defects	☐ Yes	☐ No
Down Syndrome	☐ Yes	☐ No
Tay-Sachs Disease	☐ Yes	☐ No
Hemophilia/Blood Disorders	☐ Yes	☐ No
Sickle Cell Trait	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Huntington's Disease (Chorea)	☐ Yes	☐ No
Autism Spectrum Disorder	☐ Yes	☐ No
Other inherited genetic disorder	☐ Yes	☐ No
Previous child with defect not listed	☐ Yes	☐ No
Recurrent pregnancy loss or stillbirth	☐ Yes	☐ No
Any other genetic disease not listed above	☐ Yes	☐ No

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DOB _____

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Date _____

SOCIAL HISTORY

Marital/Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Number of Children _____ Lives with ☐ Spouse ☐ Partner ☐ Children ☐ Alone Other _____

Highest Level of Education _____ Occupation _____

Number of years in Florida (or native) _____ States prior to Florida _____

Do you have religious or cultural beliefs that would affect your medical treatment? ☐ Yes ☐ No

Do you have religious or cultural beliefs that would prevent you from accepting a blood transfusion during a life-threatening emergency? ☐ Yes ☐ No

If Yes to any of the above, describe _____

NUTRITION/EXERCISE

Nutrition ☐ Excellent Diet ☐ Good Diet ☐ Average Diet ☐ Poor Diet ☐ Vegetarian

Exercise ☐ Yes ☐ No ☐ How Often _____ ☐ Exercise Type _____

TOBACCO/ALCOHOL/DRUGS

Do you currently use tobacco? ☐ Yes ☐ No Type/Daily Amount _____ How Long _____

Have you used tobacco in the past? ☐ Yes ☐ No Type/Daily Amount _____ How Long _____

Do you use alcoholic beverages? ☐ Yes ☐ No Type/Weekly Amount _____ How Long _____

Additional drugs you have tried (street or prescription)? _____

How Much/How Often _____

DEMOGRAPHIC AND ADDITIONAL INFORMATION

Primary Language _____

Ethnicity ☐ White ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose Not to Disclose

Race (check all that apply) ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black/African American

☐ American Indian/Alaska Native Other _____ ☐ Choose Not to Disclose

---

Assigned Sex at Birth ☐ Female ☐ Male ☐ Choose Not to Disclose

Sexual Orientation ☐ Straight or Heterosexual ☐ Lesbian, Gay or Homosexual ☐ Bisexual ☐ Don't Know

☐ Something else, please specify _____ ☐ Choose Not to Disclose

---

Gender Identity ☐ Female ☐ Male ☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female)

☐ Gender Neutral (neither exclusively male or female)

☐ Other Gender, please specify _____ ☐ Choose Not to Disclose

Pronouns ☐ He/She ☐ She/Her ☐ They/Them

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DOB _____

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Date _____

INSTRUCTIONS TO OBTAIN/RELEASE HEALTH INFORMATION

IMPORTANT

1. Please read all instructions and information before completing and signing the form.
2. Fees: Release of records directly to the patient or authorized representative may result in a fee per page. There is no charge to release records for continuity of care (provider to provider).
3. Incomplete Forms may result In processing delays if the required information is not completed on the form. Incomplete forms may not be accepted.

INSTRUCTIONS

The following information will help you with filling out the required sections on the form.
Please type or print as clearly and completely as possible.

Section I **PATIENT AND REQUESTOR INFORMATION**
Fill in the patient's information completely.

Section II **PERSON/FACILITY AUTHORIZED TO *OBTAIN* THE PROTECTED HEALTH INFORMATION**
Fill in the person or facility name where the records being released should be SENT TO.

Section III **PERSON/FACILITY AUTHORIZED TO *RELEASE* THE PROTECTED HEALTH INFORMATION**
Fill In the person, provider, or facility that is responsible to RELEASE the medical records.
Please fill out the form as completely as possible to eliminate processing delays.

Section IV **THE FOLLOWING PROTECTED HEALTH INFORMATION MAY BE RELEASED**

1. Please fill in the date range for the period of healthcare to be released.
2. Select what type of records to be released.
   Please note the boxes to the right. This contains a special authorization to release sensitive health information.
   These lines must be initialed in order for the records to be released.
3. Select how requested records should be delivered, whether to be picked up in person, or delivered by Fax/Mail.

   Please note, there is a box that can be checked if you would like to be enrolled In our online Patient Health Portal.
   If you select this box, please make sure that your email address is clearly written in Section I.
   You will receive an email regarding your registration shortly after submitting this form.

   Purpose of this Request: Select the correct box corresponding to why these records are being released.

SIGNING THIS REQUEST: Patient or Legal Representative. This will be signed by the patient who's records are being released. If the patient is unable to sign, it may be signed by their legal representative. If a Power of Attorney or Healthcare Surrogate is signing for the patient, please be sure Administration has a copy of the patient's Advance Directives.

PLEASE CONTACT
SPACE COAST HEALTH CENTERS

951 N. Washington Ave., Suite 100
Titusville, FL 32796
321-268-6836

5005 Port St. John Pkwy., Suite 2400
Cocoa, FL 32927
321-877-2700

SPACE COAST HEALTH CENTERS INC.
A Florida not-for-profit corporation

Patient _____

DOB _____

Athena Pt ID _____

Date _____

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

Section I PATIENT AND REQUESTOR INFORMATION

Patient Last Name _____ First Name _____ Middle _____

Mailing Address _____ City _____ State _____ Zip _____

Phone # _____ Email Address _____

Section II PERSON/FACILITY AUTHORIZED TO *OBTAIN* THE PROTECTED HEALTH INFORMATION

☐ Space Coast Health Centers
951 N. Washington Ave.
Titusville, FL 32796
Office/Dept: 321-268-6836
Fax:321-225-4786

☐ Space Coast Health Centers
5005 Port St. John Pkwy.
Cocoa, FL 32927
Office/Dept: 321-877-2700
Fax: 321-806-3059

☐ Other (Specify Person/Facility/Address)
_____
_____

Section III PERSON/FACILITY AUTHORIZED TO *RELEASE* THE PROTECTED HEALTH INFORMATION

☐ Parrish Medical Center
951 N. Washington Ave.
Titusville, FL 32796
Office/Dept: 321-268-6280
Fax: 321-268-6280

☐ Space Coast Health Centers
951 N. Washington Ave.
Titusville, FL 32796
Office/Dept: 321-268-6836
Fax: 321-225-4786

☐ Space Coast Health Centers
5005 Port St. John Pkwy.
Cocoa, FL 32927
Office/Dept: 321-877-2700
Fax: 321-806-3059

☐ Other (Specify Person/Facility/Address)
_____
_____
_____
_____
_____

Section IV THE FOLLOWING PROTECTED HEALTH INFORMATION MAY BE RELEASED (Check boxes below)

Covering the period(s) of health care from _____(date) to _____ (date)

☐ All Records
☐ Hospital Abstract
☐ Radiology Reports
☐ Other (specific report(s) list below)

☐ Office Abstract
☐ Radiology Images
☐ Lab/Pathology Results

_____

_____

I further authorize the release of the following information which may be included In the Protected Health Information (please Initial).

☐ Behavioral Health _____
☐ Substance Use Disorder _____
☐ STD/HIV/AIDS Treatment(s) or Test(s) _____
☐ Genetic Testing _____

Delivery of Requests ☐ Pick Up in Person ☐ Deliver by Fax/Mail ***Radiology Image Requests*** ☐ Disc Given/Sent to Patient ☐ Disc Sent to Facility

☐ **Please enroll me in the online Patient Health Portal**

Purpose of this Request ☐ Treatment/Continued Care ☐ Payment/Billing ☐ Personal Use ☐ Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so In writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my Insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____

If I fall to specify an expiration date, this authorization will expire in one year.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the privacy officer at 321-268-6835. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extant indicated and authorized herein.

Signed Patient or Legal Representative _____ Date/Time _____

Witness _____ Date/Time _____