English Only / 영문으로 써주세요

Hope Family Medicine 행복한 가정의학과

REGISTRATION FORM

Patient Information 환자 정보			
First Name 이름 Middle Name Last Name 성		Date of Birth / / 월Month 일Day 년Year	Sex ◯M 남 ◯F 여
Home Address 집주소 Street Apt/Unit City State Zip Code			
Cell Phone Number 전화번호	Email		
Emergency Contact Name 비상 연락처 이름	*Emergency Contact Number 비상 연락처*		
*Pharmacy 약국 **(꼭 써주세요)***	*Pharmacy Address 약국 주소 **(꼭 써주세요)***		

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA), in order for your physical or the staff of Hope Family Medicine to give copies of any/or discuss your conditions, exams, etc with members of your family or other individuals that you designate other than your specialists, we must obtain your authorization prior to doing so. We must also obtain your authorization to discuss financial information with members of your family or other individuals when you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be reviewed.

☐ I authorize to receiving SMS(text), Email, and/or Call from Hope Family Medicine

Release of Information (의료기록을 이메일 및 우편 보내는 승인)

☐ Using email or mail to release medical records as per my request. I understand it may not be secured.

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

_____

Medication Access Authorization (약국에서 약 정보 검토 및 다운로드 승인)

☐ To obtain/download medication information from my pharmacy/via EMR.

Immunization Access Authorization (조지아 주 보건 예방 접종 정보 업데이트 승인)

☐ I authorize (동의) HFM to download or update my immunization information to the Georgia Department of Health Immunization Registry.

I acknowledge receipt of the Notice of Privacy Rights in accordance with the Health Insurance Portability and Accountability Act about how Hope Family Medicine may use and disclose my protected health information. I understand Hope Family Medicine reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.

The patient or guarantor is responsible for payment in full of all services rendered by the physicians or employees of Hope Family Medicine with Express Care LLC. Payment in full is expected at the time of services unless arrangements are made in advance.

Authorization, Assignment, and Responsibility of Account

I hereby authorize Hope Family Medicine with Express Care LLC to release to the above insurance companies and/or carriers any medical or other information needed for claim reimbursement.

_____ _____

Signature *Date*

HOPE
Family Medicine
행복한 가정의학과

REQUEST OF MEDICAL RECORDS

PATIENT NAME: GENDER: M / F	DATE of BIRTH:

Request from:

_____

Phone:_____ Fax:_____

- ❑ Progress Notes
- ❑ Imaging Reports
- ❑ Lab Reports
- ❑ All Medical Records
- ❑ Other: _____

☐ No Records Found for Requested Patient

Release my protected health information to the following Clinic:

Name : Hope Family Medicine (행복한 가정의학과)
Address: 80 Horizon Dr. Ste. 304 Suwanee, GA 30024
Tel: (770) 476-3734
Fax: (770) 613-3928

By signing this form, I authorize the 'Request from" to release confidential health information regarding me s(the patient), by releasing copies of my medical records, or a summary or narrative of my protected health information to Hope Family Medicine.

_____ _____
Signature Date