



**Current Height:** \_\_\_\_\_ **Current Weight:** \_\_\_\_\_ **Date of Last Physical Exam (or mo/yr):** \_\_\_\_\_

Do you have any current or past **medical conditions**? Please check all that apply:

**General**

- Cancer
- Weight Changes
- Currently/Possibly Pregnant
- Currently Breastfeeding

**Cardiovascular**

- Coronary Artery Disease
- Heart Surgery
- Hypertension
- Abnormal Blood Pressure
- High Cholesterol
- Fainting Spells

**Respiratory**

- Emphysema
- Asthma
- Sleep Apnea

**Endocrine**

- Diabetes
- Thyroid Problems

**Musculoskeletal**

- Broken Bones
- Fibromyalgia
- Chronic Fatigue Syndrome
- Arthritis
- Rheumatic disease

**Genitourinary**

- Kidney/Bladder Problems
- Sexually Transmitted Disease
- HIV/AIDS/ARC
- Urinary Incontinence

**Blood/Lymph**

- Cirrhosis
- Anemia
- Hepatitis

**Skin**

- Acne
- Skin Disorders
- Tuberculosis

**Neurological**

- Stroke
- Head Injury
- Headaches
- Epilepsy / Seizures
- Memory Loss

**Gastrointestinal**

- Ulcers
- Abdominal Pain
- Nausea
- Diarrhea
- Constipation

**Allergies/Immune**

- Hay Fever
- Immunosuppressed

**Eyes/Ears**

- Visual Problems
- Hearing Impaired

**Previous hospitalizations (including psychiatric):** \_\_\_\_\_

**Previous surgeries:** \_\_\_\_\_

Are you **allergic** to any foods or medications?  No  Yes - please list:

Allergic to: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergic to: \_\_\_\_\_ Reaction: \_\_\_\_\_

Are you currently taking any **prescription medications**?  No  Yes

If yes, please **attach a list** or list each medication **name** and **dosage** if known (*i.e. 20mg as needed or 5mg daily*):

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

# ASSOCIATED CLINIC OF PSYCHOLOGY

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## AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MENTAL HEALTH INFORMATION TO A PRIMARY CARE PHYSICIAN

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Client Name (please print) Date of Birth

THIS FORM WHEN COMPLETED AND SIGNED BY YOU, AUTHORIZES ACP TO RELEASE PROTECTED PERSONAL HEALTH INFORMATION TO YOUR PRIMARY CARE PHYSICIAN FOR CONTINUITY OF CARE PURPOSES.

\*Check **one** of the boxes listed below.

- I do not have a primary care physician.***
- I do not authorize ACP to contact my primary care physician.***
- I authorize ACP to exchange information with my primary care physician.***

PHYSICIAN NAME: \_\_\_\_\_  
CLINIC NAME: \_\_\_\_\_  
CLINIC ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
TELEPHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_

AT THE REQUEST OF THE INDIVIDUAL, THE FOLLOWING INFORMATION IS RELEASED:  
Client Summary: This may include any of the following: Medication, Treatment Plan, Discharge Summary.

*I understand this information will be disclosed to the above person, organization, or agency from records whose confidentiality is protected by Federal Laws (42 CFR Part 2) and by Minnesota Statutes. I also understand that I may revoke this authorization at any time by giving written notice to the Associated Clinic of Psychology, except to the extent that action has already been taken in reliance upon it. Unless revoked earlier or otherwise indicated, this authorization will expire one year from the date of signing.*

*I understand that my clinician generally may not condition psychological/psychiatric services upon my signing an authorization unless the psychological/psychiatric services are provided to me for the purpose of creating health information for a third party. Furthermore, I understand that information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.*

SIGNATURE OF CLIENT: \_\_\_\_\_ DATE: \_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN (IF APPLICABLE): \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
IF PATIENT IS UNABLE TO SIGN, REASON: \_\_\_\_\_