Authorization to Use or Disclose Protected Health Information

The Drugless Doctors

Name:	DOB:
Address:	Phone #:
City/State:	Zip:
Email:	Date of Request:

As required by the Privacy Regulations, The Drugless Doctors may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)
Interpretation of said images

Effective dates for this authorization: _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature or Patient or Patient's Authorized Representative *Date*

Authorized Signature of Facility *Date*

Breast Thermography Confidential Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

	Yes	No
1. Do you have any close relative who has had breast cancer?	☐	☐
2. Have you ever been diagnosed with breast cancer?	☐	☐
3. Have you ever been diagnosed with any other breast disease (fibrocystic)?	☐	☐
4. Have you had any biopsies or surgeries to your breasts?	☐	☐
5. Have you had any breast cosmetic surgery or implants?	☐	☐
6. Have you had a mammogram in the past 12 months?	☐	☐
7. Have you had a mammogram in the past 5 years?	☐	☐
8. Have you had abnormal results from any breast testing?	☐	☐
9. Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10. Have you suffered with cancer of the womb?	☐	☐
11. Have you had pharmaceutical hormone replacement therapy?	☐	☐
12. Do you have an annual physical examination by a doctor?	☐	☐
13. Do you perform a monthly breast self exam?	☐	☐

14. How many mammograms have you had in total? _____

15. What was your age when you had your first mammogram? _____

16. How many births have you had? _____ **Your age at birth of first child:** _____

17. Did your periods start before the age of 12? _____**Or finish after the age of 50?** _____

18. Do you smoke? Yes Never Not in last 12 months Not in last 5 years

Have you recently had any of these breast symptoms:	**Right Breast.**	**Left Breast**
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

PATIENT DISCLOSURE

I understand that the Report generated from my images is intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis. I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the Images with respect only to the thermographic findings discussed in the Report.
By signing below, I certify that I have read and understand the statements above and consent to the examination.

_____

Signature or Patient or Patient's Authorized Representative *Date*

Extended Breast Questionnaire

To be completed if you have previously been diagnosed with Breast Cancer or breast disease.

BREAST CANCER INFORMATION

Date of Diagnosis (mm/yyyy): _____

Cancer Type: Metastatic _____ Local _____ Lymph Node _____

Left Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

Right Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

Treatment(s): Surgery _____ Chemotherapy _____ Radiation _____ None _____

Other: _____

OTHER BREAST DISEASE INFORMATION

Date of Diagnosis: (mm/yyyy): _____

Disease Type: Fibrocystic _____Cystic _____ Mastitis _____ Abscess _____

Other: _____
(Please report other types of disease in the history)

BREAST BIOPSIES OR SURGERIES

Left Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

Right Breast: UO _____ UI _____ LO _____ LI _____ Nipple _____

REQUEST FOR ALTERNATIVE COMMUNICATIONS

Name:_____

Address:_____

_____

Date of Birth: _____ Date of Request:_____

As allowed by the Privacy Regulations, I wish for this office to provide the following "Alternative" means of communicating my Protected Health Information:

☐ **Mailing Address**.
If appropriate, please contact me at the following address:
_____

☐ **Phone.**
If appropriate, please contact me by telephone at the following number:
_____

☐ **Fax.**
If appropriate, please contact me by fax at the following number:
_____

☐ **E-Mail.**
If appropriate, please contact me by E-mail at the following E-mail address:
_____

☐ I have the following additional requests for confidential communications regarding my Protected Health Information (Please explain):
_____

_____

_____

I understand that there may be additional costs associated with this request and I agree to reimburse this office for such costs.

_____ _____
Signature Date

☐ Accepted as requested. ☐ Modified as noted: _____

_____ _____
Authorized Signature of Facility Date

THE DRUGLESS DOCTORS
Chiropractic, Family Health, and Wellness

Include as much information as possible. If you do not have a response to a question, please indicate by writing “None”.

Age: _____

Gender: _____

Occupation: _____

Primary Care Physician: _____

Clinical Concerns: _____
_____
_____

Current Symptoms: _____
_____

Current Treatment: _____
_____

Current Medication(s): _____
_____

Thermogram History: _____
_____

Previous Report #'s: _____

Results of clinical correlation: _____

Mammogram/Ultrasound History: _____
_____

Family History: _____
_____

Ob/Gyn History: _____
_____

Surgical History: _____
_____

Dental History: _____
_____

General History: Diagnoses: _____
_____

Skin Lesions/ Physical Abnormalities: _____
_____

Notes:_____
_____
_____

Examples for Reference

HISTORY AND SUBJECTIVE COMPLAINTS

Age: (eg. 45)

Gender: *(eg,Fema/e)*

Occupation: *(eg, retired hairdresser)*

Primary Care Physician: *(eg, John Smith MD.)*

Clinical Concerns: *(eg, obesity and diet give concern for early diabetic change and DJD* of *both knees, blood sugar is in the high normal) or (None... establishing baseline)*

Current Symptoms: *(eg, intermittent stabbing pain in both knees for the last* 6 *months, aggravated by standing /walking, relieved by rest.) or (No symptoms)*

Current Treatment: *(eg, Physiotherapy and acupuncture when started, for how long, results, etc.)*

Current Medication: *(eg, Occasional Tylenol for pain) or (if generic drug name not known, class* of *drug is helpful: anti-hypertensive, anti-cholesterol, anti-diabetic, anti-inflammatory, etc)*

Thermogram History: *(eg,* 1*study 2005 for pain in left elbow) or (Baseline breast) or (annual breast, no changes reported) or (suspicious finding in left breast, recommended follow-up)*

Previous Report #'s: *(if known)*

Results of clinical correlation: *(eg, exam by PCP negative) or (Nurse found lump and referred patient to breast specialist) or (patient* has *not sought clinical opinion since last thermal exam)*

Mammogram/Ultrasound History: *(eg, no suspicious results) or (small calcifications UOQ left breast considered benign) (when, area/location, opinion, follow-up, recommendations, outcome)*

Family History: *(eg, cancer, heart, diabetic etc)*

Ob/Gyn History: *(eg, cervical cancer, ovarian/uterine cysts, endometriosis hysterectomy etc)*

Surgical History: *(eg,'appendix, thyroidectomy, cosmetic, C-section, Gallbladder, etc)*

Dental History: *(eg, implants upper left, root canals lower left and right, dentures, amalgam fillings lower left premolars, gum disease, etc)*

General History: *(eg, accidents, injuries, diseases, conditions, high risk issues, smoking/chemical exposures! etc)*

Diagnoses: *(eg, diabetes, hypertension, CAD, Hernia, etc etc etc.) (when and how diagnosed)*

Skin Lesions or Physical Abnormalities: *(eg, tattoos, piercing, scars, wounds, missing first finger on left hand, etc etc)*

Notes: _____