**Please do not mail this questionnaire – fax or email it. Thank you**.

Please also forward us any relevant prior evaluations, school or therapy reports. This is helpful information for us in planning for your childs visit.

**Intake History Questionnaire**

Child’s name:

Child’s date of birth:

Parents’ names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who referred you for this evaluation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer all of the following questions, which will help us plan for your child’s evaluation.

What concerns do you have about your child’s development and/or behavior?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What information would you like to gain from this evaluation?

**MEDICAL HISTORY**

Birth History

Child’s weight at birth? lbs oz

How many weeks gestation? weeks,

What type of delivery?

 Vaginal delivery ( normal/spontaneous Pitocin induced)

 Cesarean section – if so, was this due to:

 repeat

 fetal distress

How old was the mother at the time of delivery? Years

What number pregnancy was this (e.g. 1st, 2nd, etc.)?

If any prior pregnancies, how many resulted in a delivery?

Hospital where child was born?

Was your child adopted? Yes No

If yes, where was your child born?

How old was your child when he/she was placed in your care?

Was your child conceived through in vitro fertilization? Yes No

Did the mother receive fertility therapy? Yes No

Was your child a singleton or a multiple birth? Singleton Multiple

If a multiple birth, how many children were delivered?

What were their birth weights?

Were there any maternal medical problems during the pregnancy? Yes No

If yes, what was/were the problem(s)?

 Bleeding Diabetes Infection Hypertension \_\_\_\_\_\_\_Other

Were any medications taken during the pregnancy? Yes No

If yes, please list medication(s) and reasons taken?

Did you have a fetal sonogram? Yes No

Result(s) of sonogram(s)? Normal Abnormal

If abnormal, please explain:

Was the infant’s stay in the nursery:

 Uneventful Complicated

If complicated, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did the infant leave the hospital with mother after usual post-partum stay? Yes No

Medical History

Please write any medical or behavioral diagnoses that your child has been given.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child had or been diagnosed with any of the following conditions:

ADHD Yes No

Anemia Yes No

Anxiety Yes No

Asthma Yes No

Atopic Dermatitis Yes No

Atrial Septal Defect Yes No

 Autism Spectrum Disorder Yes No

Cardiac Arrhythmia Yes No

Cerebral Palsy Yes No

Chronic Lung Disease Yes No

Concussion

Depression Yes No

Developmental Delay Yes No

Ear infections Yes No

Feeding Difficulties

Genetic Disorder Yes No

GERD (Gastric reflux) Yes No

GI Problem (other) Yes No

Hearing Loss Yes No

Heart murmur Yes No

Intraventricular Hemorrhage Yes No

Jaundice (Neonatal) Yes No

Meningitis Yes No

Motor Skills Delay Yes No

Pica Yes No

 Plagiocephaly

Scoliosis Yes No

 Sensory Processing disorder

Seizure Disorder Yes No

Speech Delay Yes No

Torticollis

Urinary Tract Disorder Yes No

Ventricular Septal Defect Yes No

Visual Impairment Yes No

If yes to any of the above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever been hospitalized? Yes No

Has your child had a serious injury? Yes No

Has your child had any of the following surgical procedures?

 Adenoidectomy Yes No

Tonsillectomy Yes No

Tympanostomy Tube Placement Yes No

Strabismus Surgery Yes No

Sinus Surgery Yes No

Hernia Repair Yes No

 Hypospadias Repair Yes No

 Gastrostomy Tube Yes No

 Nissen Fundoplication Yes No

 Orthopedic surgery Yes No

 Tendon Release Yes No

 Tracheostomy Yes No

 Ventriculoperitoneal Shunt Yes No

 Other Yes No

If yes to any of the above, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Current and Past Medications and Supplements

Medication/ Start Date/

Supplement Dose Reason for Taking End Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Does your child have known allergies to food or medications? Yes No

If yes, please list:

Are your child’s immunizations up to date? Yes No

**DEVELOPMENTAL HISTORY**

Please list the ages at which your child:

Rolled over Sat up

Stood up Walked alone

Pointed Said mama/dada

Single words 2 - word phrases

Toilet trained: During the day At night:

School History/Type of Classroom:

Toddler groups/classes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nursery School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pre K\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kindergarten\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade 3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade 5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade 6\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade 7\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade 8\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of: Students \_\_\_\_\_\_\_\_ Teachers \_\_\_\_\_\_\_\_\_\_ and Aides \_\_\_\_\_\_\_\_\_

Behavioral History

Please check any of the following that you feel could describe your child;

Hyperactive \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Inattentive \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Defiant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aggressive\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Passive \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Easily upset\_\_\_\_\_\_\_\_\_\_\_\_\_

Clumsy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Toe walker\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fearful \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anxious \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cooperative\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friendly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Affectionate\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rigid\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child ever had any of the following evaluations?

 Evaluator Date General Findings

Audiology/Hearing test:

Vision:

Physical Therapy:

Occupational Therapy:

Speech & Language:

Psychology:

Neurology:

Developmental Pediatric: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric:

Genetics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child received any therapies?

 Frequency Start Date End Date

Physical Therapy:

Speech & Language Therapy:

Occupational Therapy:

SEIT Services:

ABA Therapy: \_\_\_ \_\_\_\_\_\_

1:1 Paraprofessional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other:

Pediatric care is provided by:

Doctors Name:

Address:

Sleep & Feeding:

Child usually goes to sleep at PM Child wakes up at \_\_\_\_\_AM

Child does / does not sleep through the night?

Is there any snoring, difficulty breathing during sleep, nightmares?

Does the child sleep in a crib or bed?

Does he/she share a room?

Does you child still nap/ how often?

Please describe your child’s diet:

Is your child on a special diet?

Does your child feed him/herself ; with fingers ?\_\_\_\_\_\_\_\_\_\_\_\_ with utensils ?\_\_\_\_\_\_\_\_\_

Can your child: Dress self\_\_\_\_\_\_\_\_\_\_ Buttons\_\_\_\_\_\_\_\_\_ Zippers\_\_\_\_\_\_\_\_\_\_ Tie Laces\_\_\_\_\_\_\_

**FAMILY COMPOSITION**

Mother/Father name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_ Education level \_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_
(please circle one)

Mother/Father name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_ Education level \_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_

(please circle one)

Please list the child’s siblings:

\* Name age male / female

\* Name age male / female

\* Name age male / female

Does anyone else live in the family home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a regular caretaker other than parents? \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­\_\_\_\_

Languages spoken in the home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there any biological family history of the following conditions:**

Allergies Yes No

Anxiety Disorder Yes No

Asthma Yes No

Attention deficit disorder Yes No

Autism Spectrum Yes No

Bipolar Disorder Yes No

Depression Yes No

Developmental Disability Yes No

Genetic Disorder Yes No

Heart Disease Yes No

Hypertension Yes No

Intellectual Disability Yes No

Learning Disability Yes No

Obsessive Compulsive Disorder Yes No

Schizophrenia Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If your child is **under 5 years** of age please complete the following:

My child feeds him/herself with fingers Yes No Sometimes

My child feeds him/herself with utensils Yes No Sometimes

My child can drink from an open cup Yes No Sometimes

My child can wash his/her hands and face Yes No Sometimes

My child can brush his/her teeth Yes No Sometimes

My child can undress him/herself Yes No Sometimes

My child can dress him/herself Yes No Sometimes

My child performs simple household chores Yes No Sometimes

My child plays appropriately with toys Yes No Sometimes

My child can play independently Yes No Sometimes

My child shares his/her toys well Yes No Sometimes

My child enjoys playing with other children Yes No Sometimes

My child asks for friends by name Yes No Sometimes

My child can play a turn taking game Yes No Sometimes

My child enjoys playing dress up Yes No Sometimes

My child comes to greet me when I come home Yes No Sometimes

My child shows separation anxiety when I leave Yes No Sometimes

My child spontaneously expresses affection Yes No Sometimes

My child comforts other children in distress Yes No Sometimes

My child shows pride in his/her accomplishments Yes No Sometimes

My child brings me toys and books to share Yes No Sometimes

My child will ask for help if needed Yes No Sometimes

My child will say please and thank you Yes No Sometimes

My child follows directions Yes No Sometimes

My child responds when I call his name Yes No Sometimes

My child uses gestures to communicate Yes No Sometimes

My child uses words to communicate Yes No Sometimes

My child uses sentences to communicate Yes No Sometimes

My child asks questions Yes No Sometimes

My child uses the following # of words < 5, 5 to 20 , 20 to 50 , More than I can count

My child walks well Yes No Sometimes

My child can walk up and down stairs Yes No Sometimes

My child runs well Yes No Sometimes

My child will play ball games Yes No Sometimes

My child participates in team games Yes No Sometimes

My child can scribble Yes No Sometimes

My child can draw a recognizable figure Yes No Sometimes

My child can write his/her name Yes No Sometimes

**Race and Ethnicity Information**

We want to make sure that all our patients get the best care possible. We would like you to tell us your child’s racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

**Primary Language**

[ ]  Albanian [ ]  American Sign Language [ ]  Arabic [ ]  Armenian

[ ]  Bengali [ ]  Bosnian [ ]  Cantonese (Chinese)

[ ]  Creole [ ]  Croatian [ ]  ECH [ ]  Danish

[ ]  English [ ]  French [ ]  German [ ]  Greek

[ ]  Hebrew [ ]  Hindi [ ]  Indonesian [ ]  Italian

[ ]  Japanese [ ]  Korean [ ]  Latin [ ]  Malay

[ ]  Mandarin (Chinese) [ ]  Persian [ ]  Polish

[ ]  Portuguese [ ]  Romanian [ ]  Russia [ ]  Serbian

[ ]  Slovak [ ]  Spanish [ ]  Swahili [ ]  Swedish

[ ]  Tagalog [ ]  Thai [ ]  Turkish [ ]  Urdu

[ ]  Vietnamese [ ]  Yiddish [ ]  Yugoslavian [ ]  Other

[ ]  Declined [ ]  Unknown

**Race**

[ ]  American Indian or Alaska Native [ ]  Asian

[ ]  Black or African American [ ]  Native Hawaiian or Other Pacific Island

[ ]  White [ ]  Other Combination Not Described

[ ]  Declined

**Ethnicity**

[ ]  Hispanic or Latino or Spanish Origin

[ ]  Not Hispanic or Latino or Spanish Origin

[ ]  Declined

# **Pharmacy Intake Form**

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child’s prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

[ ]  New [ ]  Update

Date:

Patient Name:

NYH #:

**PRIMARY**

Pharmacy Name:

Address:

Phone Number:

Fax Number:

**SECONDARY** (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number:

**Authorization To Disclose Health Information Via E-Mail**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST: \_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization covers protected health information (PHI) disclosed by Weill Cornell Medical College (WCMC) personnel to a patient or a patient’s representative through e-mail communication. It expires when the need to communicate via e-mail is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

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My signature at the bottom of this form is authorization for WCMC to disclose the health information of the above-named patient via e-mail. It also confirms my understanding that:

• Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Re-disclosure may no longer be protected by law.

• I should not use e-mail for any urgent or time-sensitive medical questions or issues

• Once transmitted, I am responsible for safeguarding the information I receive

• I have the right to revoke this authorization at any time before information is disclosed by submitting to the Privacy Office a WCMC Revocation of Release of Medical Information Form # PO012B. A revocation will not apply to information that has already been released as a result of this authorization

• To initiate e-mail communication, I will send an e-mail from my e-mail address, containing my request for information, to the WCMC party at the e-mail address below

• I am responsible for notifying the WCMC party listed below if my e-mail address changes and completing another authorization in order to communicate using a different address

• If I am communicating via e-mail about someone else, I attest that I am responsible for that person’s care or payment and will indicate my relationship to the patient below

• WCMC will not condition treatment or payment upon receipt of an authorization

The e-mail address I wish to use is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Print name Relationship to patient

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Name of WCMC party (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WCMC e-mail: \_\_\_pedschilddevelopment@med.cornell.edu, ckm2003@med.cornell.edu, kmt2003@med.cornell.edu \_\_

WCMC, please indicate date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_, retain a copy of this request in the patient’s file, and provide a copy of the original to the requestor