PATIENT NAME **AGE** **VISIT DATE**

List ALL DOCTORS you currently see:

OCCUPATION or GRADE IN SCHOOL

PLEASE LIST THE MAIN REASONS FOR YOUR VISIT	When did problems begin?

Please list **ALL** recent & current medications, vitamins, herbs, etc.	

History of ANTIBIOTIC use:

EAR – NOSE – THROAT – CHEST ALLERGIC SYMPTOMS

EYES	EARS	NOSE	SINUS	THROAT	CHEST
__ Itch __ Redness __ Tearing __ Burning __ Discharge __ Blurring __ Contact lens use	__ Itch __ Feel full __ Popping __ Ringing __ Reduced hearing __ Prior surgery/tubes __ Frequent infections	__ Itch __ Sneezing __ Clear runny __ Thick nasal discharge __ Stuffy / congestion __ Discolored mucus __ Polyps __ Bloody noses __ Mouth breather	__ Drainage __ Pain or pressure above, below or behind eyes __ Dark circles under eyes __ Bags under eyes __ Frequent sinusitis __ Prior sinus surgery __ Positive findings on sinus CT or X-rays	__ Frequent sore throats __ Itch __ Post-nasal drainage __ Clear throat often __ Voice cracks / gravely __ Bad taste __ Bad breath __ Hoarse __ Snoring	__ Asthma __ Wheezing __ Chest tightness __ Shortness of breath __ Easily winded __ Chest cough is __ Dry __ Wet __ Thick __ Upon arising __ In the middle of night

Above conditions worse when exposed to:

__ DUST __ CATS __ DOGS __ HORSES
__ GRASS __ TREES __ AIR-CONDITIONING __ HEAT
__ COLD __ WINDS __ CHANGE OF WEATHER __ ODORS
__ TOBACCO SMOKE __ FUMES __ DAMP/FOG

Other:

Condition is worse:

__ INDOORS __ OUTDOORS __ EARLY AM __ LATE AT NIGHT
__ DURING DAY __ AT SCHOOL __ AT HOME __ IN BEDROOM
__ AT WORK __ AFTER EXERCISE __ AROUND MENSES __ AFTER EATING
__ SPRING __ SUMMER __ FALL __ WINTER

Other:

How often do you have the above symptoms? __ Daily __ 2-3 times a week __ 2-3 times a month __ 1/month __ less than monthly __ 2-3x a year

How long do symptoms last? ____ Minutes ____ Hours ____ Days ____ Weeks ____ all the time _____# of school/work days missed due to the above?

Number of ER/hospitalization visits for asthma/allergies:

DRUG REACTIONS: __ Aspirin? __ Penicillin? __ Sulfa? Other (list)_____

Describe your reaction to the above _____

FOOD REACTIONS: _____

INSECT or TICK reactions: _____

Have you ever been skin tested for allergies? Blood tested for allergies? When results:

HOME and WORK ENVIRONMENT

List everywhere you have lived:

How long have you lived in your home? _____ Is your home near industry?____ Powerlines/transformers?____ Freeways/heavy traffic?____ Wilderness?____

How old is present home? _____ Do you have forced heating/cooling?____ Special filter system?____ Water purification system?____ Wi-Fi?____

Does your home have a mold/mildew/dampness problem? ____ Carpet age _____ years condition:_____ ever flooded?_____

Does anyone smoke indoors?___ How much exposure do you have (or have had) to chemicals, pesticides, paint, etc._____

IN YOUR BEDROOM: carpet?____ curtains?____ mini-blinds?____ waterbed?____ mattress age ____ years stuffed animals?____ a lot of pillows?____

Do you use a down comforter?____ feather pillows?____ allergy cover on mattress?___ allergy cover on pillows?____ curtains?____

LIST PETS indoors at home (_____) and outdoors (_____)

AT WORK/SCHOOL IS THERE CONTACT: __ Animals? __ Poor ventilation? __ Odors/Mildew? __ Chemical use? __ Fumes? __ Wi-Fi/EMF?

How is your school/work performance or health affected by the environment?

List where you have traveled:

CARDIOVASCULAR

__ Chest pains (Angina)
__ Mitral valve prolapse
__ Palpitations/heart pounding
__ Irregular heart beat
__ Heart beats fast or races
__ Easily winded with slight effort
__ Had a Stress Test when?_____
__ High blood pressure
__ Low blood pressure
__ Low blood count (anemia)
__ Low iron __ Low B12
__ Had a heart calcium scan (CAC)
__ Gums bleed after brushing
__ Bruise easily
__ Prior stroke or TIA
__ Feet swell up
__ Varicose veins ☐ Thrombosed
__ Spider veins
__ Dizzy or light-headed
__ Dizzy when stand up
__ Poor circulation
__ Hands / feet fall asleep
Your highest cholesterol level_____
__ High triglycerides

MUSCULOSKELETAL & CALCIUM METABOLISM

__ Arthritis LIST in order of severity:
__ Painful joints

__ Joints click or creak
__ Stiffness with prolonged sitting
__ Stiff in the morning
__ Low back pain
__ Pain between shoulder blades
__ Neck pain
__ Degenerative joint disease
__ Have crushed vertebrae
__ Joints injure easily
__ Heel or Foot pain
__ Tremor or shakiness
__ Numbness or reduced sensation
__ Balance difficulty
__ Poor coordination
__ Tingling
__ Muscle cramps ☐ at night?
__ Muscle spasms or tenderness
__ Muscles weak/fatigue easily
__ Bursitis
__ Carpal Tunnel Syndrome
__ Osteoporosis / Osteopenia / Bone loss
__ Chiropractic adjustments don't stay/hold
__ Kidney stones (type:)
__ Build up dental tartar or plaque rapidly
__ Gingivitis/gum disease/inflammation
__ Loss of gingiva/ gingival recession
__ Dental cavities recently
__ Loss of dental bone
__ Root canals ☐ Painful/sensitive
How many crowns do you have?_____

MISCELLANEOUS

__ Swollen lymph glands
__ Sensitivity to fumes, smoke, EMF smog, chemicals, odors, etc.
__ Sensitivity to most medicines or herbs
__ Significant chemical exposures at work
__ Significant EMF expsoure
__ Awaken to urinate ____ times
__ Dribble after urinating
__ Burning with urination
__ Urinate small amount at a time
__ Kidney infections
__ Frequent bladder infections
__ Kidney disease
__ Stream force is reduced
__ Prostate trouble / Prostatitis
__ Impotency/Trouble with erections
__ Difficulty holding urine
__ Incontinence/leakage
__ Glaucoma
__ Reduced Night Vision
__ Macular Degeneration ☐Right ☐ Left
_ Silicone/Saline implants (yr placed:)

MEDICAL and SURGICAL HISTORY

CHILDHOOD: weeks born premature?____ low birth weight?_____ complications of pregnancy or delivery?_____
newborn jaundice?_____ diarrhea?_____ vomiting or regurgitation?_____ breastfed _____ mos
formula soy___ milk___ colic?___ croup?___ bronchiolitis/bronchitis?___ (age(s)_____)
Are immunizations up to date?___ normal development?__ ☐ Issues with development In daycare or preschool _____ days/wk

List MAJOR ILLNESSES or INFECTIONS	
List PREVIOUS THERAPIES and YOUR RESPONSE	
List all HOSPITALIZATIONS, OPERATIONS, DENTAL PROCEDURES, CAR & OTHER ACCIDENTS, ETC. (include dates)	

DIETARY PROFILE

Alcohol intake per week _____ Tobacco ___packs/day for ___years (quit 19____) Cups of caffeinated coffee per day ___
Colas or sodas _____ cans/day "Sugar-free" products per day ___ ☐ Aspartame Red meat eaten _____/week Fish eaten _____/week
Do you use margarine? __ Do you eat dairy products regularly?___ Do you drink tap water?___ purified?__ distilled?__
Antacids taken _____/week Birth Control Pills for _____years Recreational drug use (THC, etc.) _____
How much fruit juice do you consume/day?_____ How many servings of fruit/day?____ How many servings of vegetables/day?_____

List FOOD RESTRICTIONS:

What Foods do you CRAVE or eat a lot of?

What do you typically eat?	Breakfast
	Lunch
	Dinner

SOCIAL HISTORY

Marital status: How long? years Ages of children: Ages of Siblings:

SPORTS HOBBIES

LIST THE MAJOR SOURCES OF STRESS IN YOUR LIFE	

Rate your satisfaction on a scale from 1 (poor) - 10 (great) of your JOB ____ MARRIAGE____ HEALTH ____ GENERAL LIFE ____

FAMILY HEALTH HISTORY

__ Alcoholism / Addiction
__ Atherosclerosis
__ Allergies
__ Asthma
__ Attention deficit
__ Autism
__ Alzheimer's at what age
__ Autoimmunity
__ Diabetes
__ High blood pressure
__ Obesity/Excessive weight
__ Thyroid disorders
__ Anxiety
__ Early menopause
__ Emphysema/Lung disease
__ Mood Disorders
__ Osteoporosis
__ Osteoarthritis
__ Depression
__ Insomnia
__ Heart disease
__ Migraines
__ Strokes
__ Cancer (list types:
__ IBS
__ Parkinson's Disease
List other family conditions

Place one [X] if condition is chronic and two [XX] if condition is acute/significant. Leave all others blank.

IMMUNITY, INFECTIONS and RESISTANCE

__ Takes a long time to heal	__ Problem with boils	__ Infections settle in lungs	__ EBV positive	__ Have had MRSA cultured
__ Catch colds easily	__ Warts	__ Pneumonia(s) in 19_____	__ HHV6 positive	__ Mycoplasma positive
__ Have had shingles	__ Frequent cold sores	__ Frequent "bronchitis"	__ Herpes 1 and/or 2	__ Positive TB skin test
__ Toenail fungal infections	__ Frequent canker sores	__ Many bladder infections	__ CMV positive	__ Lyme positive
__ Yeast infections	__ Have been HPV positive	__ Recurrent streptococcal infections	__ H pylori positive	

CHRONIC FATIGUE

What was triggering event?	When did it start

__ Fatigue all day	__ Fatigue mostly in afternoon	__ Fatigue just after meals	__ Fluctuating energy levels	__ Exhausted after slight effort
__ Onset was sudden	__ Onset was gradual	__ Must nap ____ hours a day	__ Flu-like feelings (malaise	__ Muscles ache like after exercise

What makes it worse?	What makes it better?

AUTONOMIC & ACID-BASE

__ Feverish (temp_____)	__ Dry mouth	__ Cold hands or feet	__ Chilled when stressed	__ Rapid digestion
__ Night sweats	__ Strong gag reflex	__ Yawn frequently	__ Watery eyes or nose	__ Hard to fall asleep at night
__ Flu-like symptoms	__ Easily startled	__ Fingers or lips tingle	__ Eyes blink often	__ Staring, blinks little
__ Swollen lymph nodes	__ Make goosebumps easily	__ Unable to relax	__ Always hungry	__ Strong light irritates
__ Sweaty/clammy palms, soles, forehead, or underarms		__ Slow starter in the am	__ Perspire easily	

GLUCOSE REGULATION and METABOLISM

__ Hypoglycemia ☐ w/(+) test	__ Afternoon headaches	__ Awaken after a few hours of sleep for no reason	__ Eat when nervous or upset
__ Excessive appetite	__ Eating relieves fatigue	__ Am still hungry even after a large meal	__ Hungry or irritable between meals
__ Have to eat frequently	__ Get shaky, lightheaded or heart pounds if hungry or meals delayed.	I crave __candy/sweets __chocolate __alcohol __breads __coffee	

HEADACHES and DENTAL HISTORY

Location of headaches:	Headaches began

__ Head throbs or pounds (migraines)	__ Headaches are dull/pressure	__ Past head/neck injury	__ Shoulders & upper back ache	__ Stiff neck
__ Car or other major accidents	__ Grind teeth/bruxism	__ Jaw pops, locks, grind	__ Clench teeth	____ # of dental fillings
__ Have had orthodontic work	__ Sleep preferentially on 1 side	__ Neck trigger points	__ Carry tension in neck/upper back	____ # of root canals
__ Headaches are "splitting"	How long does your headache last			

What helps	Triggers

BRAIN CHEMISTRY and FUNCTION

__ Restless, uneasy sleep	__ Depressed, not motivated	__ Anxious, nervousness	__ Moody	__ High pain threshold
__ Awaken in the night ____ times	__ Suicidal thoughts	__ Highly emotional	__ Irritable or angry	__ Poor concentration
__ Awaken in a.m. unrested	__ Withdrawn socially	__ Worrier or feel insecure	__ Mind races	__ Forgetful/poor memory
Usual number hours of sleep ____	__ Reduced initiative	__ Poor school/work performance	__ History of seizures	__ Cloudy/foggy thinking
__ Prominent dreams	__ Tend to procrastinate	__ Attention deficit disorder	__ Learning Disorder	__ Hyperactive or very restless

WHAT IS YOUR DOMINANT EMOTIONAL RESPONSE(S): __ Fear __ Worry __ Anxiety __ Anger __ Frustration __ Impatience __Sadness

☐ Check here if you would like to complete a more comprehensive questionnaire regarding brain neurotransmitters and chemistry.

ENDOCRINE GLANDS and HORMONES

__ Thyroid disorder	__ Can't get weight up to normal	__ Premenstrual anxiety/irritability	__ Menopause in _____	
__ Low body temperature	__ Weight loss (_____lbs.)	__ Premenstrual bloating/water gain	__ Night or cold sweats	__ Hot flashes
__ Sensitivity to cold	__ Weight gain (_____lbs.)	__ Premenstrual depression/crying	__ Vaginal dryness	__ urinary tract symptoms
__ Sensitivity to heat		__ Premenstrual acne/skin outbreaks	__ Mood/mentation changed with menopause	
__ Thick puffy dry skin	WHAT IS YOUR IDEAL WT?_____	__ Menses are irregular in interval	__ Surgical hysterectomy in _____☐ovaries taken	
__ Swollen or bulging eyes	When did you last weigh this?_____	Days between periods _____		
__ Low sex drive		Days of flow:_____	__ Breast tenderness or cysts	
__ Low sex responsiveness	__ Always thirsty	__ Heavy flow __ Light flow	__ Have had an abnormal Pap smear	☐HPV positive
__ High sex drive	__ High blood sugar/diabetes	__ Clots __ Brown flow	__ Ovarian Cysts	
__ Crave salt	__ Hot flashes	__ Menstrual cramps	__ Vaginal itch, discomfort, or discharge	

☐ Check here if you would like to complete a more comprehensive questionnaire regarding hormone balance.

SKIN

__ Itching	__ Dandruff	__ Dry skin	__ Eczema	__ Hives
__ Corners of mouth crack	__ Psoriasis	__ Rashes	__ Chapped lips	__ Rough skin on back of arm
__ Brittle fingernails	__ Flushing or blotches	__ Sunburn easily	__ Acne or pimples	__ Oily skin ☐ only on face
__ White nail spots	__ Stretch marks	__ Foot odor	__ Thick skin on heels/feet	__ Hair loss

GASTROINTESTINAL-DIGESTION

__ Burning tongue	__ Coated tongue	__ Bad breath/halitosis	__ Parasites __SIBO	__ Hemorrhoids
__ Burping or belching	__ Bloating after meals	__ Gas/flatulence	__ Intestinal bloating	__ Elevated liver enzymes
__ Heartburn or sour taste	__ Fatty food intolerance	__ Acidic foods upset stomach	__ Groin rash or itch	__ Have had hepatitis
__ Nausea	__ Pain between shoulder blades	__ Foul smelling stool	__ Itching around anus	__ Have had polyps
__ Metallic/bitter taste	__ Gallstones	__ Pain/cramps in lower abdomen	__ Colonoscopy last done	
__ Stomach pain/upset before meals	__ Light/clay colored stools	__ Black or bloody stools	__ Constipation or hard stools	
__ Stomach pain/upset after meals	__ Past ulcer or gastritis	__ Loose bowel movements (diarrhea) ☐Unformed	Bowels move_____a day	

THIS PRIVATE NON-NEGOTIABLE CONTRACT MUST BE FULLY COMPLETED and RECEIVED BY OUR OFFICE BEFORE YOUR 1st CONSULTATION

Oct 2020

Patient's Last Name:_____ First Name:_____ Middle Initial:_____ Marital status_____

Home Address:_____ Home phone: (_____)-_____ Soc Sec # xxx -xx-_____

City, State:_____ Zip:_____ Birth date:_____

Fax # for correspondence:_____ Email:_____ Cell Phone:_____

Employer:_____ City :_____ Work ph: (_____)-_____Ext:_____

Person responsible for payment:_____ Relationship to patient:_____

Address if not same as above _____ Soc Sec #_____-_____-_____

Employer:_____ City :_____ Work phone: (____)-_____ Ext:_____

Other parent or
Emergency contact:_____ Day Phone: (_____)-_____ Relationship to patient:_____

How did you hear about us (please be specific)? _____ ☐ Friend ☐ PPO ☐ My doctor ☐ Internet

INSURANCE & BILLING INFORMATION: Insurance Co _____ ☐No Insurance ☐Medicare ☐Tricare ☐HSA ☐FSA

We need a photocopy of your Policy Card and a full-length photo

ANNUAL DEDUCTIBLE $_____ Will you meet it this year? _____

JEK MD Inc is **not a contracted provider for any insurance carrier** and as such you are responsible for full payment of all charges at the time of service.

☐ For patients with **MEDICARE** or **TRICARE:** at this location Drs. Kaslow is not an authorized provider and cannot bill either Medicare or Tricare under any circumstance for any services provided. In addition, you must sign an additional form before any care is provided. Ask if you did not receive it.

For those with insurance other than Medicare and Tricare, we *may* submit an insurance claim on your behalf for possible reimbursement directly to you. Your insurance policy may cover all, some, or none of the services/products provided or may discount your reimbursement. This does not affect the amount you will owe, and checks sent to us from the insurer will be returned. Some services/products are considered research or investigational; others historically have never been reimbursed. Claims for these services/products will not be submitted. If you do not have a list of those services/products, ask for an updated fee schedule.

Please ask beforehand if you are not sure about what will be submitted to your insurance company. Experience has shown that submitting some services/products delays or causes insurance companies to deny the entire claim. If an insurance carrier requests reports or your records, we will ask you for authorization to reply beforehand and may charge you additional fees to prepare such requests. If you do not have a list of our approximate fees, please ask for an updated fee schedule.

Many but not all lab services performed outside the office are billed directly by the lab, who may be contracted with your insurance carrier. Most labs will bill you or the insurer directly. Some lab services require prepayment or do not bill insurance. Our office will inform you beforehand.

☐ I understand that I will be charged for failing to show up to my appointment(s) or canceling an appointment less than 2 full working days beforehand.

☐ By agreeing to receive care and services in this office I am authorizing JEK MD Inc to store the credit card/debit card/HSA or FSA card I provided.

☐ For **PARENTS of MINORS:** Occasionally your child may need medical treatment when you are unavailable. Your signature (s) below indicates agreement and authorization for Jeremy E Kaslow MD and /or Thanh Coughlin, DO to perform any primary or consultative care for the purposes of examination, diagnosis, referral, research, or treatment of your child.

Because of the occasional parental disagreement about the approach or care of a minor, **BOTH** parents or legal guardians must sign this form before Dr. Kaslow and/or Coughlin will evaluate or treat your child. Both parents must understand and agree in concept to the nature and approach of this practice. This authorization shall remain effective until your child is age 18 unless revoked in writing and received by this medical office.

I hereby authorize Jeremy E. Kaslow, MD and /or Thanh Coughlin, DO to render any procedure deemed necessary in evaluating, diagnosing and treating me or my dependent in an irrevocable hold-harmless agreement. I also authorize him to furnish information to my insurance carrier concerning the services provided. I understand and accept full responsibility for all charges incurred. I will pay any legal costs I incur to or on this office, as well as any and all collection costs if my balance becomes delinquent (45 days after service). I authorize JEK MD Inc (dba True Health Partners) to charge the credit/debit/HSA or FSA card I provided.

The sole purpose of my consultation is for personal health care, and I am not part of an investigation or inquiry about Drs. Kaslow and/or Coughlin or any aspect of this practice. Signature below indicates irrevocable agreement to the above terms as a private non-negotiable contract.

☐ I/We received and reviewed the office policy. ☐ I/We reviewed the privacy policy of this office (HIPAA).

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California, 800-633-2322, www.mbc.ca.gov

Signature(s) of Responsible Person(s):_____ Date:_____

If patient under 18, both Mother AND Father must sign

- True Health Partners -
FAX to 714-565-1035 or e-mail to frontdesk@drkaslow.com with any diagnostic reports available

Oct 2020

POTENTIAL PATIENT BACKGROUND

Date Sent to Patient:_____

Patient's Name:	Patient's occupation:
Date of Birth:	If minor, both parents names:
Street Address:	
City, State, Zip:	
❑ Home Phone #:	❑ Mobile Phone #:
❑ Work Phone #:	Fax #:
Email Address:	

Please check off best daytime phone number and time of day to contact you.

Best Day(s) for Appointment:	❑ Monday ❑Tuesday ❑Wednesday ❑Thursday ☐Friday
Best Time of day for Appointment:	❑ Anytime ❑ Early am(8-10) ❑ Late am(10-12) ❑ Early afternoon (2-3:30pm) ❑ Late afternoon (4-5pm)
Insurance Carrier:	❑PPO ❑POS ❑HMO ❑Medicare/Tricare ❑None
Insurance for "Out of Network" Coverage/Restrictions:	
What are your financial limitations:	❑None ❑Can't afford anything beyond small co-pays ❑Can not afford any out of pocket expenses
How did you hear about us (be specific please)?	
What major medical issues concern you?	
Summarize your specific health goals:	
How much time do you expect for results?	
List type of treatments you have tried:	
How committed are you to following a nutritional program?	
List any special considerations (vegan, sensitivities, etc):	
Have you reviewed our website, www.drkaslow.com?	

_____ ← Initial here to acknowledge that Drs. Kaslow and Coughlin at this location are not affiliated with any PPO, HMO or medical group, payment in full at time of service is expected for all patients, and that you will be billed for missed appointments and late cancellations. Lab fees and nutritional supplements, herbs, etc. are not included in the office consult charges. Your initials indicate 1) you understand the basic philosophy of this medical practice; 2) you are seeking consultative care only for health reasons; and 3) any interaction with this office is considered part of a Private Non-Negotiable Contract with JEK, MD Inc. (dba True Health Partners). Both/all legal guardians of a minor must initial here and sign an informational contract in order to initiate care.

PLEASE ALSO FAX, MAIL, or E-MAIL (frontdesk@drkaslow.com) A COPY OF ANY RECENT/RELEVANT LABORATORY REPORTS. If you have a brief summary of your medical needs or history, a time-line of major or relevant life events include this as well.

---------- *For Office Response Only* ----------

MRR: get all❑ get lab only❑ get others if any❑
INFO: send NP packet❑ Prolo❑ ASD initial❑
?AIRES: Homeo❑ NTI❑ Neurochem❑ DOSHA❑ ANS❑
SCHED: 1st avail JEK❑ Routine JEK❑ with TC ❑ DNS❑
TESTS BEFORE VISIT: Lab❑ Genetics❑ OAT❑ RGCC❑
BE PREPARED at 1st VISIT for hTMA❑ Fasting AM lab❑
SCHED at 1st visit: NLS+❑ BRT❑ A❑ Prolo❑
SCHED at 1st visit: HMAHOT❑ UBI/MAHT❑

_____ _____
_____
_____
_____

WAIVER of HIPAA - UNSECURED E-MAIL and/or FACSIMILES and AUTHORIZATION to SHARE MEDICAL INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets standards for protecting the rights of individuals (patients). Individually identifiable health information should be protected with reasonable administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure. Our medical office complies with the laws that grant every individual the right to the privacy and confidentiality of their health information. To comply with HIPAA regulations, e-mail correspondence that contains protected health information must be sent encrypted (secured). Until our office has developed such as platform, if you wish to have any e-mail sent or facsimile phoned to you in unencrypted (unsecure) manner, you must initial the appropriate sections below, provide the e-mail address or facsimile numbers, and sign and date the following waiver:

_____ I request that, for my convenience, Jeremy E. Kaslow, M.D., Charles W. Penick, M.D., and/or Thanh Coughlin, D.O. and any of the True Health Partners office staff may correspond with me by **unencrypted (unsecure) e-mail**. I understand that e-mails sent to me may contain protected health information. I further understand that unencrypted e-mail and e-mail attachments are not secure and may be viewed by others.

_____ I request that, for my convenience, Jeremy E. Kaslow, M.D., Charles W. Penick, M.D., and/or Thanh Coughlin, D.O. and any of the True Health Partners office staff may correspond with me by **text or voice messaging** via mobile or cellular phone services. I understand that these communications may contain protected health information. I further understand that messaging may not be secure and may be viewed or heard by others.

_____ I request that, for my convenience, Jeremy E. Kaslow, M.D., Charles W. Thanh Coughlin, D.O. and any of the True Health Partners office staff may correspond with me by facsimile. I understand that telephone facsimiles may contain protected health information. I further understand that facsimiles are not secure and may be viewed by others.

____ I agree to hold harmless Jeremy E. Kaslow, M.D., Charles W. Penick, M.D., Thanh Coughlin, D.O., JEK MD Inc (dba True Health Partners) and its officers, agents, employees, and contract health providers from any and all liability, loss, damages, costs, or expenses which are sustained, incurred, or required arising from the transmission of unencrypted (unsecure) e-mail, text, voice messaging, facsimile correspondence and attachments.

I hereby authorize and direct True Health Partners to send all e-mails, text and/or voice messages in an unencrypted (unsecure) format to the following e-mail address(es) and/or phone number(s):

_____ _____

_____ _____

This waiver will remain in force until revoked in writing. It may be revoked in writing at any time.

☐ I authorize Jeremy E. Kaslow, M.D. and/or Charles W. Penick, M.D. and/or Thanh Coughlin, D.O. and True health Partners office staff/employees to **share any and all of my medical information** with the following individuals (include phone and/or e-mail):

_____

Signed _____ Date:_____

Request for Release of Records to True Health Partners

Patient: _____ Date of Birth:_____

SSN: XXX-XX-__ __ __ __ Medical Record Number:_____

From DOCTOR(s), CLINIC(s) or HOSPITAL(s):

Date faxed

❑_____ fax:_____

❑_____ fax:_____

❑_____ fax:_____

❑_____ fax:_____

Effectively immediately, I hereby authorize and request you to release by mail or facsimile or e-mail to:

True Health Partners
Jeremy E. Kaslow, M.D., F.A.C.P., F.A.C.A.A.I.
Thanh Coughlin, D.O.
720 North Tustin Ave Ste 202
Santa Ana, CA 92705-3606
714-565-1032 FAX 714-565-1035
frontdesk@drkaslow.com

- ❑ All medical records concerning any aspect of my medical care.
- ❑ All medical records concerning any aspect of my medical care beginning _____.

- ❑ Only diagnostic data such as lab, biopsy, radiograph, imaging, spirometric, EKG, skin testing, or other test reports.
  - ❑ the beginning of my illness or my first visit with you or your group.
  - ❑ since this date only_____.

The medical records requested are only to be used for medical care. They will not be released to another party without specific written authorization. A photocopy or facsimile of this request shall be as valid as the original and remain in effect for 12 months from the date of signature below. I may revoke this authorization in writing effective at any time. My next appointment with Dr. Kaslow and/or Coughlin is _____.

Thank you for your cooperation and rapid response.

Signed:_____ / Witness: _____ Date:_____

PROHIBITION OF RE-DISCLOSURE and CONFIDENTIALITY NOTE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you making any further disclosure without the specific written consent of the persons to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

The information released is intended only for the use of the individual(s) or entity(s) listed above and is confidential and legally privileged.

Oct 2020