Cedar Valley Medical Specialists
We specialize in you.

Mail to: Cedar Valley Medical Specialists, P.C.

Attn: _____

_____

Standard Authorization to Use or Disclose Protected Health Information (PHI)

Section A: I give my permission to release health information for the individual listed below. Read the following information to make sure that it is correct:

Name: _____

Social Security Number: _____ Date of Birth: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Section B: Office/Physician that will provide this health information:

Name: CEDAR VALLEY CARDIOVASCULAR CENTER
A Division of Cedar Valley Medical Specialists, PC
Address: 419 East Donald St., Waterloo, IA 50703
319-236-1911

Section C: This information is to be sent to:

Name: _____

_____

Address: _____

_____

Section D: Describe the specific Protected Health Information to use or disclose, including date(s):

MUST BE COMPLETED BEFORE RECORDS RELEASED

☐ **Complete Medical Record** [This would include Psychiatric (mental health) information, HIV, and/or Aids related diagnosis, evaluation information, and Substance Abuse (Drug or Alcohol) information]

☐ **Partial Medical Record - Do not include the following areas of my records in this release:**

- ☐ Psychiatric (mental health) information
- ☐ HIV and/or Aids related diagnosis, evaluation information
- ☐ Substance Abuse (Drug or Alcohol) information

For the following dates of service: _____

Describe the reason for the release or request of information: _____

☐ At the request of the individual or ☐ Other _____

Section E: I understand that:

- This authorization is voluntary. I am not required to sign this form. CVMS does not condition treatment, payment, benefit eligibility, or enrollment activities on the signing of this form. If I do not sign this form, CVMS will not disclose my health information as requested.
- I may revoke this authorization at any time by notifying in writing the company/individual listed in Section B from providing the PHI identified in this authorization, but if I do revoke this authorization, it won't have any effect on any CVMS actions before they received the revocation.
- Once my health information is disclosed as requested in this authorization my health information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed.
- Information used as a result of this authorization may not be further disclosed by CVMS without the written authorization of the person to whom it pertains.
- I may receive a copy.

Section F: Signature

I hereby authorize the use or disclosure of the Protected Health Information as described in Section D for the individual listed in Section A. This authorization will expire in one year.

Signature of Individual/Individual's Personal Representative: _____ Date: _____

Section G: If Section F is signed by a Personal Representative, please complete the information below:

Personal Representative's Name: _____

Relationship to Individual: _____

Personal Representative's Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Personal Representative's Area Code & Telephone Number: _____

Date Sent: _____ Initials: _____

Faxed to: _____ Picked up by pt: _____ Mailed to: _____

CEDAR VALLEY CARDIOVASCULAR CENTER
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419 East Donald St. • Waterloo, IA 50703 • Phone: (319) 236-1911 • Fax: (319) 287-5832
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Kari N. Haislet, DNP, ARNP
Lisa L. M. Maher, DNP, ARNP
Abbie J. M. Schrader, MSN, ARNP
Abbie L. Schaa, MSN, ARNP
Erica Jensen, MSN, ARNP

PVD (Peripheral Vascular Disease) Questionnaire

Name:_____ Date of Birth: _____ Date: _____

1. Do you suffer aching, cramping or pain in your arms, legs, thighs, or buttocks when you walk or exercise? YES NO

2. If yes to above, does the pain get better when you rest? YES NO
   If so, how long do you need to rest before the pain subsides? _____

3. Have you ever been told that you have peripheral vascular disease or blockages in any blood vessels other than your heart? YES NO

4. Do you have Diabetes? YES NO

5. Have you ever been told that you have an aneurysm? YES NO
   If so, where is it located? _____

6. Do you have any sores or ulcers on your legs or feet that are having trouble healing? YES NO

7. Have you ever had a thrombus (blood clot) in any of your blood vessels? YES NO

8. Do you anticipate any possible surgery on any of your limbs? YES NO

Patient Signature: _____

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Sleep Apnea Questionnaire

Name:_____ Date of Birth:_____ Date:_____

1. Do you have diagnosed Sleep Apnea? YES NO
   If YES, please answer question #2.
   If NO, please skip to question #3.

2. Do you use a prescribed CPAP or BiPAP? YES NO
   If NO, Why not?

   _____

   _____

   _____

   _____

3. Do you regularly feel un-refreshed, even after waking from a full night's sleep? YES NO

4. Do you fall asleep easily during your waking hours, while at home or at work? YES NO

5. Are you a loud, habitual snorer? YES NO

6. Has your bed partner witnessed you choking, gasping, or holding your breath during sleep? YES NO

7. Do you often suffer from poor concentration or judgment, memory loss, irritability and/or depression? YES NO