

**CONSENTS THAT HAVE TO BE
SIGNED BEFORE CHILDREN'S
MEDICAL RESOURCE NETWORK
WILL BE ABLE TO SEE THE
CHILDREN**

**MUST BE SIGNED BY THE
CUSTODIAL PARENT, LEGAL
GUARDIAN, OR DCFS IF THE CHILD
IS A WARD**



Southern™
 Illinois University
 School of Medicine

Children's Medical Resource Network
 Kathy D. Swafford, M.D., Medical Director
 Ginger L. Meyer, M.S.W., L.C.S.W., Medical Social Worker

PO Box 179
 Anna, IL 62906

618.833.6488
 Fax: 618.833.1599

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ hereby authorize SIU School of Medicine/Children's Medical
 (Person Signing Authorization)

Resource Network to furnish the following medical information to _____

 (Name and Address of Facility)

Patient's Name: _____ Date of Birth: _____

Specific Information to be Released: _____ Date of Treatment: _____

- | | |
|---|---|
| <input type="checkbox"/> History and Physical-Medical | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Social History/Assessment | <input type="checkbox"/> Other _____ |

I understand that this authorization includes information regarding mental health, developmental disability, alcohol and/or drug abuse services, and HIV test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

This authorization expires 1 year from the date of issue. I understand that I have a right to revoke this authorization at any time and for any reason, and that such revocation will be honored except to the extent of any action already taken on this authorization prior to revocation. I also understand that I have a right to inspect and have copied all information to be disclosed pursuant to this authorization.

Signed: _____ Date: _____
 (Patient/Guardian)

If signed by other than the patient, please indicate relationship to patient, and why patient did not sign: _____

Witness: _____ Date: _____



Southern™
 Illinois University
 School of Medicine

Children's Medical Resource Network

Kathy D. Swafford, M.D., Medical Director
 Ginger L. Meyer, M.S.W., L.C.S.W., Medical Social Worker

PO Box 179
 Anna, IL 62906

618.833.6488
 Fax: 618.833.1599

CONSENT FOR PHOTOGRAPHS

I, _____, hereby authorize representative of SIU School of Medicine/Children's Medical Resource Network, my physician(s) or other designated person(s) to photograph, videotape or use other appropriate electronic media recording of me (hereafter collectively referred to as photographs) while under the care of the above named facility with the following restrictions: (write none if no restrictions – do not leave _____ blank) _____

I understand that these photographs of me are to document my medical condition, or for clinical educational and identification purposes. I further understand that, based on the reason for the photographs they may be maintained as a permanent part of my medical record. I understand the photographs that are maintained by the facility are made a permanent part of my medical record, release of which shall be in accordance with applicable medical information regulations and laws.

I release and hold SIU School of Medicine/Children's Medical Resource Network, its employees, agents, or affiliates and my physician or his/her designees harmless from any and all liability, claims, demands or causes of actions whatsoever arising from and in any way associated with taking, displaying or use of these photographs.

This release and indemnification shall be as broad and inclusive as is permitted by the State of Illinois. If any portion is held invalid, the balance shall continue to be in force and effect.

I certify that I have read, understand and agree to the terms of this consent and release.

 Signature of patient or authorized representative

 Date

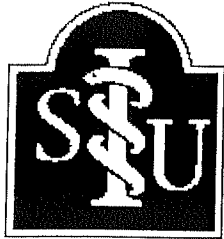
 Time

 Relationship of authorized representative

 Interpreter (if utilized)

 Second Witness if telephone consent

 Witness



Southern™
 Illinois University
 School of Medicine

Children's Medical Resource Network

Kathy D. Swafford, M.D., Medical Director
 Ginger L. Meyer, M.S.W., L.C.S.W., Medical Social Worker

P.O. Box 179
 Anna, IL 62906

618.833.6488
 Fax: 618.833.1599

REGISTRATION FORM

(Please Print)

PATIENTS NAME: _____
 (First) (Middle) (Last)

DOB: _____ AGE: _____ F _____ M _____

ADDRESS: _____ Home phone: _____
 (street or mailing address)

 (City) (State) (Zip Code) School or Daycare: _____

SS #: _____ - _____ - _____

Who referred you to our office? _____

PERSON (OTHER THAN PARENTS) TO CONTACT IN CASE WE CANNOT REACH YOU:

(Name) _____ (Phone #) _____

(Address) _____

PRIMARY CARE PHYSICIAN & CITY: _____

PARENT OR GUARDIAN INFORMATION:

MOM _____ DOB _____ SS# _____ - _____ - _____

EMPLOYER _____ PHONE # _____

DAD _____ DOB _____ SS# _____ - _____ - _____

EMPLOYER _____ PHONE # _____

INSURANCE INFORMATION:

Name of Insurance: _____

Name of Insured: _____ Group # _____

Member ID #: _____ Employer Insurance Plan?(yes/no) _____

Medicare/Medicaid #: _____

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESSING OF THIS CLAIM. I ALSO AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN FOR HER SERVICE(S) AS DESCRIBED HEREIN.

SIGNED: _____ DATE: _____

ID # _____

Patient ID _____
(will be assigned by CMRN)

Month of exam _____

Medical Examination**Patient Information**

Name (Last, First, Mi)		Date of Birth (M/D/Y)	Age
Insurance/Medicaid Number		Social Security Number ____ - ____ - ____	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Race:	
Patient Address (include street address)			
City	State	Zip	
County	Phone		
Examining Provider Information			
Hospital or Clinic Name: Children's Medical Resource Network		Address of Hospital or Clinic 109 Denny Industrial Drive	
Name of Medical Provider conducting the exam (Last, First, MI) Swafford, Kathy D., M.D.		Phone (618)833-6488	
License Number 036-074783		Person(s) assisting during the exam:	
Signature of Medical Provider		1155 East Vienna, Suite C Anna, IL 62906 (618)833-6488	
Information Regarding Examination			
Date of Exam: (M/D/Y)		Time of Exam: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	

Patient was accompanied to visit by: (list names of people that came to the exam)

I hereby request a medical examination for evaluation of physical or sexual abuse treatment, as needed. I understand that collection of evidence may include photographing injuries and that photographs may include the genital area. I further understand that hospitals and physicians are required to notify the Department of Children and Family Services of known or suspected child abuse. If child abuse is found or suspected, this form and any evidence will be released to the Department of Children and Family Services, Law Enforcement, Children's Advocacy Center, and or the Prosecuting Attorney. Demographic data and case review will be provided to the Medical Director of the Children's Medical Resource Network. (Parental consent for an evidential exam is not required in cases of known or suspected child abuse)

Signature of (Circle one) Parent/Guardian _____ Date _____

Witness Signature _____ Date _____

****Not for secondary release. This information is confidential and cannot be released without prior consent. All medical examination reports must be released from the original source. ****