

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

**PATIENT REGISTRATION**

PLEASE COMPLETE ALL ENTRIES									
<b>PATIENT NAME</b>					<b>LOCAL ADDRESS</b>				
Last Name _____					Street _____				
First Name _____ MI _____					City _____				
<b>HOME ADDRESS</b>					State _____				
Street _____					ZIP _____				
City _____ State _____ ZIP _____									
Email _____			HOME PHONE _____		CELL PHONE _____			Is iPhone <input type="checkbox"/> No <input type="checkbox"/> Yes	
PATIENT DATE OF BIRTH _____		PATIENT SSN _____		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____			
PATIENT EMPLOYER NAME _____				PATIENT EMPLOYER ADDRESS			EMPLOYER PHONE _____		
				Street _____					
				City _____ State _____ ZIP _____					
INSURED/RESPONSIBLE PARTY INFORMATION				RELATION TO PATIENT: <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> guardian					
<b>NAME</b>			<b>ADDRESS</b>						
Last Name _____			Street _____ City _____						
First Name _____ MI _____			State _____ ZIP _____						
HOME PHONE _____		WORK PHONE _____		SSN _____		BIRTH DATE _____		EMPLOYER _____	
INSURANCE INFORMATION									
<b>PRIMARY INSURANCE NAME</b>				<b>ADDRESS (from the back of the insurance card)</b>					
				Street _____ City _____					
				State _____ ZIP _____					
GROUP NUMBER _____		ID NUMBER _____			HMO <input type="checkbox"/>	PPO <input type="checkbox"/>	INSURANCE PHONE _____		
<b>SECONDARY INSURANCE NAME</b>				<b>ADDRESS (from the back of the insurance card)</b>					
				Street _____ City _____					
				State _____ ZIP _____					
GROUP NUMBER _____		ID NUMBER _____			HMO <input type="checkbox"/>	PPO <input type="checkbox"/>	INSURANCE PHONE _____		
<b>PRIMARY DOCTOR/FAMILY DOCTOR</b>					<b>REFERRING DOCTOR</b>				
<b>IN CASE OF EMERGENCY CONTACT</b>					<b>RELATIONSHIP</b>			<b>PHONE NUMBER</b>	

Date: \_\_\_\_\_

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**Are you currently admitted to a hospital or enrolled in a Hospice or Skilled Nursing Facility?**

Yes  No  If yes please fill out the following:

Facility Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

**Are you receiving benefits from the Veterans Administration?**

Yes  No  If yes please fill out the following:

VA Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Preferred way of contact (check at least one):  Home  Cell Phone  Email  Patient Portal  Decline

**Which of the following best describe your race?**

- |   |                                    |   |   |
|---|------------------------------------|---|---|
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Black / African American | <input type="checkbox"/> Hispanic         |
| <input type="checkbox"/> Subcontinent Asian American      |                                    | <input type="checkbox"/> Asian Pacific American   | <input type="checkbox"/> Native American  |
| <input type="checkbox"/> American Indian / Alaskan Native |                                    | <input type="checkbox"/> Hawaiian                 | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> More than one race               |                                    | <input type="checkbox"/> Other                    | <input type="checkbox"/> Decline          |

Please select one ethnic group that best describes your race

- |   |   |
|---|---|
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> Non-Hispanic or Latino |
| <input type="checkbox"/> Decline            | <input type="checkbox"/> Don't know             |

**What language do you feel most comfortable using when discussing your healthcare?**

- |                                  |                                  |                                     |                                  |
|----------------------------------|----------------------------------|-------------------------------------|----------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Spanish | <input type="checkbox"/> German     | <input type="checkbox"/> French  |
|                                  |                                  |                                     | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Italian | <input type="checkbox"/> Russian | <input type="checkbox"/> Portuguese |                                  |
| <input type="checkbox"/> Other   | <input type="checkbox"/> Decline | <input type="checkbox"/> Don't know |                                  |

**how often do you use internet for gathering information?**

- |                                 |                                  |                                    |                                |
|---------------------------------|----------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Always | <input type="checkbox"/> Usually | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
|---------------------------------|----------------------------------|------------------------------------|--------------------------------|

## Medical History Forms

**Cancer Diagnosis or reason for consultation:** \_\_\_\_\_

### Past Medical History (Please check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> COPD                 | <input type="checkbox"/> High blood pressure  |
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Depression           | <input type="checkbox"/> Inflammatory Bowel Disease (Crohn's disease, colitis, etc) |
| <input type="checkbox"/> Anemia/Blood Disorder                             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Migraines/headaches  |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Diverticulitis       | <input type="checkbox"/> Neuropathy   |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Psychosis  |
| <input type="checkbox"/> Atrial fibrillation/irregular heartbeat           | <input type="checkbox"/> Fibromyalgia         | <input type="checkbox"/> Rheumatoid Arthritis                                       |
| <input type="checkbox"/> Autoimmune disorder (lupus, scleroderma, RA, etc) | <input type="checkbox"/> GERD                 | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Bipolar Disorder                                  | <input type="checkbox"/> Gout                 | <input type="checkbox"/> Stroke   |
| <input type="checkbox"/> Blood clots or pulmonary embolism                 | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Thyroid Disorder   |
| <input type="checkbox"/> BPH (prostate)                                    | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Tremors  |
| <input type="checkbox"/> CAD (coronary artery disease)                     | <input type="checkbox"/> High cholesterol     | <input type="checkbox"/> Osteoporosis   |
- Cancer, prior history \_\_\_\_\_
- Infectious disease (HIV, hepatitis, Tuberculosis, etc)? \_\_\_\_\_
- Other \_\_\_\_\_

**Have you ever received radiation therapy?** No \_\_\_\_ Yes \_\_\_\_ If yes, when? \_\_\_\_\_

Physician's Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

What area was treated? \_\_\_\_\_

**Have you ever received chemotherapy?** No \_\_\_\_ Yes \_\_\_\_ If yes, when? \_\_\_\_\_

Physician's Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Medical ID Number: \_\_\_\_\_  
 Physician: \_\_\_\_\_

**Past Surgeries** *Please list surgery, year of operation, surgeon and location (if known)*

Procedure/Operation	Date	Physician	Location

Do you have any implanted medical devices such as a **PACEMAKER, DEFIBRILLATOR**, neurostimulator, drug infusion pumps, etc?  **No**  **Yes** *If yes, please provide copy of your medical device card to front desk.*

**Allergies**

Are you allergic to any medications?  **No**  **Yes** If **yes**, name/reaction: \_\_\_\_\_  
 \_\_\_\_\_

Are you allergic to latex?  **No**  **Yes** If yes, reaction: \_\_\_\_\_

Are you allergic to IV Contrast?  **No**  **Yes** If yes, reaction: \_\_\_\_\_

Others (food, tape, environmental, etc.) \_\_\_\_\_

**Medications**

Pharmacy Name: \_\_\_\_\_ Pharmacy Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Medication	Dose	Frequency	Prescribing Physician

*Please use back of this form if you need additional room for medications*

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

### **Consent to Obtain Patient Medication History**

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Signature of Patient or Legal Guardian: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Valid for 1 year from date of signature**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

### Family History

**Father:** if living, age \_\_\_\_\_ if deceased, age at death: \_\_\_\_\_

Medical Problems \_\_\_\_\_

**Mother:** if living, age \_\_\_\_\_ if deceased, age at death: \_\_\_\_\_

Medical Problems \_\_\_\_\_

**Siblings:** # of Females \_\_\_\_\_ # of Males \_\_\_\_\_

Medical Problems/Deceased \_\_\_\_\_

**Children:** # of Females \_\_\_\_\_ # of Males \_\_\_\_\_

Medical Problems/Deceased \_\_\_\_\_

### Social History

**Marital Status:**  Single  Married  Divorced  Widowed  Separated

Spouse or significant other's name: \_\_\_\_\_

**Social Geographic history:**

Where were you born? \_\_\_\_\_

Where did you live most of your life? \_\_\_\_\_

 Do you live in this state all year round?  No  Yes

 If **no**, please provide your alternate address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Occupation/Service History:**

 Occupation: \_\_\_\_\_  Retired  Disabled, reason? \_\_\_\_\_

 Have you served in the military?  No  Yes

 To your knowledge, have you ever worked in an occupation that involved exposure to asbestos or other cancerous chemicals, fumes, or carcinogens?  No  Yes

 If **yes, describe:** \_\_\_\_\_

**Substance History:**

 Have you ever smoked?  No  Yes If **yes, what?**  Cigarettes  Cigars  Pipe

How many years? \_\_\_\_\_ Packs/number per day? \_\_\_\_\_

 If **yes**, have you quit?  No  Yes If **yes**, when? \_\_\_\_\_

 Have you ever chewed tobacco?  No  Yes How much? \_\_\_\_\_

 If **yes**, have you quit?  No  Yes If **yes**, when? \_\_\_\_\_

 Do you drink alcoholic beverages?  No  Yes

 If **yes**, how often and how much? \_\_\_\_\_

 Have you quit drinking?  No  Yes If **yes**, when? \_\_\_\_\_

 Have you or do you use street drugs?  No  Yes

 If **yes**, describe \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

### Preventative Health Maintenance

**Female:** Last mammogram: \_\_\_\_\_  
 Last pap smear: \_\_\_\_\_  
 Last colonoscopy: \_\_\_\_\_  
 Last bone density scan: \_\_\_\_\_  
 Last pneumonia vaccine: \_\_\_\_\_  
 Last influenza (flu) shot: \_\_\_\_\_

**Male:** Last PSA screening: \_\_\_\_\_  
 Last prostate exam: \_\_\_\_\_  
 Last colonoscopy: \_\_\_\_\_  
 Last bone density scan: \_\_\_\_\_  
 Last pneumonia vaccine: \_\_\_\_\_  
 Last influenza (flu) shot: \_\_\_\_\_

### Mobility Risk Assessment

1. Do you need assistance walking?  No  Yes If **yes**, do you use a  cane  walker  wheelchair?
2. Have you fallen before or been injured because of a fall?  No  Yes
3. Do you feel weaker than you used to or have less strength in your arms or legs?  No  Yes
4. Have you stopped or avoided exercise/daily activities because of a fear of falling?  No  Yes
5. Do you have foot ulcers, bunions, hammertoes, or calluses that hurt or cause you to adjust your steps?  No  Yes
6. Do you feel dizzy when you stand up?  No  Yes
7. How many falls have you had in the last 12 months? \_\_\_\_\_
8. Did you suffer an injury from you falls?  No  Yes If **yes**, please explain: \_\_\_\_\_

#### Females Only

- |  |   |
|--|---|
| 1. Age at first menstrual period: _____  | 7. Did you breastfeed? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 2. Do you still have periods? <input type="checkbox"/> No <input type="checkbox"/> Yes | 8. Have you ever taken hormone replacement therapy? <input type="checkbox"/>    |
| 3. Date or Age of last menstrual period: _____   | No <input type="checkbox"/> Yes   |
| 4. Age at first pregnancy: _____   | 9. If yes, how many years? _____  |
| 5. Number of pregnancies: _____  |   |
| 6. Number of births: _____   |   |

#### Pain Assessment

Do you have pain now?  No  Yes If **yes**, please answer the following questions.

Where is your pain located? \_\_\_\_\_

On a scale of 1-10, with 1 being very mild and 10 being the worst pain imaginable, what number is your pain?

1  2  3  4  5  6  7  8  9  10

How would you describe the pain? (e.g. aching, stabbing, burning, throbbing, sharp, dull) \_\_\_\_\_

When did your pain start? \_\_\_\_\_

Does anything make it better or worse? \_\_\_\_\_

Are you taking pain medications?  No  Yes If **yes**, what? \_\_\_\_\_

## Review of Systems

*Have you recently experienced any of these symptoms? Please select all that apply:*

### General

- Fever/Chills
- Fatigue
- Weight loss/gain \_\_\_\_\_ lbs

### Eyes and Vision

- Glasses/contacts
- Eye disease or injury
- Eye pain or pressure
- Blurred or Double vision

### Ears, nose, throat

- Hearing loss
- Ringing in ears
- Ear ache or drainage
- Sinus problems
- Nose bleeds
- Dental problems
- Dentures
- Mouth sores
- Sore throat
- Difficulty/painful swallowing
- Hoarseness or voice change
- Swollen glands in neck

### Heart/Cardiovascular

- Chest pain
- Heart Palpitations
- Dizziness
- Swollen legs/ankles

### Respiratory

- Frequent Coughing
- Spitting up blood
- Wheezing or asthma
- Shortness of breath

### Endocrine

- Loss of hair/thinning hair
- Heat/cold intolerance
- Excessive thirst

### Gastrointestinal

- Loss of appetite
- Nausea or Vomiting
- Stomach pain
- Frequent diarrhea
- Constipation
- Blood in stool

### Genitourinary

- Frequent urination
- Burning or painful urination
- Blood in urine
- Incontinence or dribbling
- Urgency
- Vaginal discharge
- Painful/irregular periods
- Sexual difficulty

### Psychiatric

- Depression
- Anxiety/Nervousness
- Sleep Disorders
- Suicidal Thoughts

### Hematology/lymphatic

- Easily bruise or bleed
- Anemia
- Slow to heal
- History of transfusion

### Musculoskeletal

- Joint pain or stiffness
- Back pain
- Muscle pain or cramps
- Cold arms or legs
- Difficulty walking

### Skin and Breast

- Rash or Itching
- Lesion or change in skin color
- Breast mass/lump
- Nipple discharge / retraction
- Open or non-healing wound

### Neurological

- Frequent headache
- Lightheaded or dizzy
- Confusion
- Speech difficulty
- Seizure activity
- Numbness or tingling
- Weakness in arms or legs



Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

### Depression Screening

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

**Advance Directives:**

Do you have a Medical Power of Attorney:  Yes  No

Do you have a Living Will:  Yes  No

Do you have an Advance Directive?  Yes  No

Do you have a donor card?  Yes  No

Do you have a DNR directive:  Yes  No

**If you answered 'yes' to any of the above questions. Please provide a copy of the document**

**Please list the names and addresses of Physicians you would like correspondence sent to:**

\_\_\_\_\_  
Physician name and phone Physician name and phone

\_\_\_\_\_  
Physician name and phone Physician name and phone

As the patient you acknowledge with the completion of this form it constitutes your complete clinical history summary

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

## Assignment of Benefits

### Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, Unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file insurance carrier payments.

### Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Advocate Radiation Oncology LLC medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

### Authorization to Release Information

I hereby authorize Advocate Radiation Oncology LLC to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Advocate Radiation Oncology LLC on behalf of myself and/or my dependents, and understand that making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
Patient / Responsible Party Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Witness\_\_\_\_\_  
Date

## HIPAA Patient Disclosure Form for Health Information

### ABOUT THIS NOTICE

We understand that health information about you is personal, and we are committed to protecting your information. We create a record of the care and services you receive at Advocate Radiation Oncology. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we may use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

The Health Insurance Portability & Accountability Act of 1996 S160.103, also known as HIPAA, defines individual personal health information (PHI) as information, including demographic information collected from an individual and to include information that is:

1. Created or received by a health care provider, health plan, employer, or healthcare clearing house.
2. Related to the past, present or future physical, mental health and/or condition of an individual past, present or future payment for provision of health care to an individual.
3. The information, therefore, that identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

The PHI can only be disclosed through a permitted disclosure (S164.502) and used by a health care provider in the following manners:

1. For treatment: We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
  2. For payment: We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
  3. For health care operations: We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
2. Uses or disclosure to a personal representative assigned by patient.
  3. Disclosure to the parents or persons acting in loco to parents to unemancipated minor.
  4. For case management, care coordination for the individual, to direct or recommend alternative treatments or therapies, health care providers or health care selling.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

I \_\_\_\_\_ am a patient of Advocate Radiation Oncology LLC and understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time by myself. This disclosure becomes effective the date it is signed and will continue until it is cancelled, changed, altered, or amended by myself or my appointed legal representative. This facility has notified me that they have a listing of all the persons and agencies or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility.

I HAVE READ THE PERMITTED DISCLOSURE FORM AND I UNDERSTAND IT.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Signature of Witness \_\_\_\_\_

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____	_____
Name of Guardian/ Representative	Legal Relationship	Date	Witness

I do hereby authorize the following to access my medical information at any time:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Medical ID Number: \_\_\_\_\_  
 Physician: \_\_\_\_\_

## Medical Records Release Form

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I authorize the use or disclosure of the above-named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

<input type="checkbox"/> All medical records	<input type="checkbox"/> Lab results/X-ray reports
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Follow up	
<input type="checkbox"/> Prior Dosimetry Plan Printout, EOT, and All Treatment DICOM Files	
<input type="checkbox"/> Other (Please specify) _____	

4. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization.

Name: **Advocate Radiation Oncology LLC**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Port Charlotte<br>3080 Harbor Blvd.<br>Port Charlotte, FL 33952<br>Tel: (941) 883-2199<br>Fax: (941) 979-5041    | <input type="checkbox"/> Fort Myers<br>15681 New Hampshire Ct.<br>Fort Myers, FL 33908<br>Tel: (239) 437-1977<br>Fax: (239) 437-1889 | <input type="checkbox"/> Cape Coral<br>909 Del Prado Blvd. S<br>Cape Coral, FL 33990<br>Tel: (239) 217-8070<br>Fax: (239) 217-8069 | <input type="checkbox"/> Tamarac<br>7850 N. University Dr.<br>Tamarac, FL 33321<br>Tel: (754) 205-0099<br>Fax: (954) 388-5849               |
| <input type="checkbox"/> Bonita Springs<br>25243 Elementary Way<br>Bonita Springs, FL 34135<br>Tel: (239) 317-2772<br>Fax: (239) 676-7637 | <input type="checkbox"/> Naples<br>1775 Davis Blvd.<br>Naples FL, 34102<br>Tel: (239) 372-2838<br>Fax: (239) 372-2839                | <input type="checkbox"/> Bradenton<br>5325 State Road 64 East<br>Bradenton, FL 34208<br>Tel: (941) 220-6263<br>Fax: (386) 490-9100 | <input type="checkbox"/> West Palm Beach<br>4832 Okeechobee Blvd<br>West Palm Beach, FL 33417<br>Tel: (561) 277-0786<br>Fax: (561) 277-0831 |

For the purpose of: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical ID Number: \_\_\_\_\_

Physician: \_\_\_\_\_

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, **this authorization will expire on the following date, event, or condition:**

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7. If I fail to specify an expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact a clinic representative at any of the Advocate Radiation Oncology locations.

\_\_\_\_\_  
Signature of patient or legal representative\_\_\_\_\_  
Printed name of representative and relationship to patient\_\_\_\_\_  
Date

**PLEASE NOTE:** This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written, and informed release of the individual to whom it pertains or as permitted by state law and federal law.