ADVOCATE
Radiation Oncology, LLC

Date: _____
Patient Name: _____
Medical ID Number: _____
Physician: _____

PATIENT REGISTRATION

PLEASE COMPLETE ALL ENTRIES

PATIENT NAME

Last Name _____

First Name _____ **MI** ____

HOME ADDRESS
Street _____

City _____ **State** _____ **ZIP** _____

LOCAL ADDRESS

Street _____

City _____

State _____

ZIP _____

Email	**HOME PHONE**	**CELL PHONE**	**Is iPhone** ☐ No ☐ Yes	

PATIENT DATE OF BIRTH	**PATIENT SSN**	**Gender** Male ☐ Female ☐	**MARITAL STATUS** ☐ Single ☐Married ☐ Other_____

PATIENT EMPLOYER NAME	**PATIENT EMPLOYER ADDRESS** Street _____ City _____ State _____ ZIP _____	**EMPLOYER PHONE**

INSURED/RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: ☐ spouse ☐ parent ☐ guardian

NAME
Last Name _____
First Name _____ **MI** __

ADDRESS
Street _____ **City** _____
State _____ **ZIP** _____

HOME PHONE	**WORK PHONE**	**SSN**	**BIRTH DATE**	**EMPLOYER**

INSURANCE INFORMATION

PRIMARY INSURANCE NAME

ADDRESS (from the back of the insurance card)
Street _____ **City** _____
State _____ **ZIP** _____

GROUP NUMBER	**ID NUMBER**	**HMO** ☐	**PPO** ☐		**INSURANCE PHONE**

SECONDARY INSURANCE NAME

ADDRESS (from the back of the insurance card)
Street _____ **City** _____
State _____ **ZIP** _____

GROUP NUMBER	**ID NUMBER**	**HMO** ☐	**PPO** ☐		**INSURANCE PHONE**

PRIMARY DOCTOR/FAMILY DOCTOR	**REFERRING DOCTOR**	
IN CASE OF EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE NUMBER**

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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?

☐ **Asian**	☐ **Caucasian**	☐ **Black / African American**	☐ **Hispanic**
☐ **Subcontinent Asian American**		☐ **Asian Pacific American**	☐ **Native American**
☐ **American Indian / Alaskan Native**		☐ **Hawaiian**	☐ **Pacific Islander**
☐ **More than one race**		☐ **Other**	☐ **Decline**

Please select one ethnic group that best describes your race

☐ **Hispanic or Latino**	☐ **Non-Hispanic or Latino**
☐ **Decline**	☐ **Don't know**

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

☐ **English**	☐ **Spanish**	☐ **German**	☐ **French** ☐ **Chinese**
☐ **Italian**	☐ **Russian**	☐ **Portuguese**	
☐ **Other**	☐ **Decline**	☐ **Don't know**	

how often do you use internet for gathering information?

☐ **Always**	☐ **Usually**	☐ **Sometimes**	☐ **Never**

ADVOCATE
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Date: _____
Patient Name: _____
Medical ID Number: _____
Physician: _____

Medical History Forms

Cancer Diagnosis or reason for consultation: _____

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

☐ Allergies	☐ COPD	☐ High blood pressure
☐ Anxiety	☐ Depression	☐ Inflammatory Bowel Disease (Crohn's disease, colitis, etc)
☐ Anemia/Blood Disorder	☐ Diabetes	☐ Migraines/headaches
☐ Arthritis	☐ Diverticulitis	☐ Neuropathy
☐ Asthma	☐ Erectile dysfunction	☐ Psychosis
☐ Atrial fibrillation/irregular heartbeat	☐ Fibromyalgia	☐ Rheumatoid Arthritis
☐ Autoimmune disorder (lupus, scleroderma, RA, etc)	☐ GERD	☐ Seizures
☐ Bipolar Disorder	☐ Gout	☐ Stroke
☐ Blood clots or pulmonary embolism	☐ Heart Attack	☐ Thyroid Disorder
☐ BPH (prostate)	☐ Heart Disease	☐ Tremors
☐ CAD (coronary artery disease)	☐ High cholesterol	☐ 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: _____

ADVOCATE
Radiation Oncology, LLC

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

ADVOCATE
Radiation Oncology, LLC

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

ADVOCATE
Radiation Oncology, LLC

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 _____

ADVOCATE
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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: _____
2. Do you still have periods? ☐ No ☐ Yes
3. Date or Age of last menstrual period: _____
4. Age at first pregnancy: _____
5. Number of pregnancies: _____
6. Number of births: _____
7. Did you breastfeed? ☐ No ☐ Yes
8. Have you ever taken hormone replacement therapy? ☐ No ☐ Yes
9. If yes, how many years? _____

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? _____

ADVOCATE
Radiation Oncology, LLC

Date: _____
Patient Name: _____
Medical ID Number: _____
Physician: _____

Review of Systems

Have you recently experienced any of these symptoms? Please <u>select</u> 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

ADVOCATE
Radiation Oncology, LLC

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

ADVOCATE
Radiation Oncology, LLC

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 and 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

ADVOCATE
Radiation Oncology, LLC

Date: _____
Patient Name: _____
Medical ID Number: _____
Physician: _____

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.

ADVOCATE
Radiation Oncology, LLC

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: _____

ADVOCATE
Radiation Oncology, LLC

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).

____ All medical records
____ Lab results/X-ray reports
____ Consultation Reports
____ Progress Notes
____ Follow up
____ Prior Dosimetry Plan Printout, EOT, and All Treatment DICOM Files
____ 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**

☐ Bonita Springs
25243 Elementary Way
Bonita Springs, FL 34135
Tel: (239) 317-2772
Fax: (239) 676-7637

☐ Bradenton
5325 State Road 64 East
Bradenton, FL 34208
Tel: (941) 220-6263
Fax: (386) 490-9100

☐ Cape Coral
909 Del Prado Blvd. S
Cape Coral, FL 33990
Tel: (239) 217-8070
Fax: (239) 217-8069

☐ Fort Myers
15681 New Hampshire Ct.
Fort Myers, FL 33908
Tel: (239) 437-1977
Fax: (239) 437-1889

☐ Naples
1775 Davis Blvd.
Naples FL, 34102
Tel: (239) 372-2838
Fax: (239) 372-2839

☐ Port Charlotte
3080 Harbor Blvd.
Port Charlotte, FL 33952
Tel: (941) 883-2199
Fax: (941) 979-5041

ADVOCATE
Radiation Oncology, LLC

Date: _____
Patient Name: _____
Medical ID Number: _____
Physician: _____

☐ Tamarac
7850 N. University Dr.
Tamarac, FL 33321
Tel: (754) 205-0099
Fax: (954) 388-5849

☐ Venice
8026 South Tamiami Trail
Venice, FL 34293
Tel: (941) 220-6460
Fax: (941) 220-5284

☐ West Palm Beach
4832 Okeechobee Blvd
West Palm Beach, FL 33417
Tel: (561) 277-0786
Fax: (561) 277-0831

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that is 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**:

_____

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.