Winning the fight against cancer, every day.®

Instructions for Returning these Forms

There are three ways to return your completed forms. Please choose the option that is most convenient for you:

1. **Email** the completed forms to your Oncology Information Specialist.
   (For this option, you need to complete and print the forms. Sign the Authorization Form and then email the scanned forms to your Oncology Information Specialist.)

OR

2. **Fax** the completed forms to the appropriate hospital.
   Eastern Regional Medical Center (Philadelphia): 215-537-5116
   Midwestern Regional Medical Center (Chicago): 847-746-6584
   Southeastern Regional Medical Center (Atlanta): 770-400-6801
   Southwestern Regional Medical Center (Tulsa): 918-249-7521
   Western Regional Medical Center (Phoenix): 623-207-3920

OR

3. **Mail** the completed forms to the appropriate hospital.
   (This option may delay processing.)

Eastern Regional Medical Center
Attention: New Patient Intake
1331 East Wyoming Avenue
Philadelphia, Pennsylvania 19124

Midwestern Regional Medical Center
Attention: New Patient Coordinator
2520 Elisha Avenue
Zion, Illinois 60099

Southeastern Regional Medical Center
Attention: New Patient Intake
600 Parkway North
Newnan, Georgia 30265

Southwestern Regional Medical Center
Attention: Intake Department—New Patient Record Collections
10109 East 79th Street
Tulsa, Oklahoma 74133-1200

Western Regional Medical Center
Attention: New Patient Intake Coordinator
14200 West Fillmore Street
Goodyear, Arizona 85338

NOTE: As a convenience to you, UPS will attempt to pick up your completed forms from the location where this package was delivered one day after the initial delivery. Simply complete the forms and place them in the included UPS envelope. There is no charge to you for this service.

PRIVACY OFFICE CONTACT INFORMATION

Eastern Regional Medical Center
215-537-7400

Midwestern Regional Medical Center
847-872-6368

Southeastern Regional Medical Center
770-400-6000

Southwestern Regional Medical Center
918-286-5355

Western Regional Medical Center
623-207-3080

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Authorization Form

Please complete all appropriate sections of these forms using either a BLUE or BLACK pen or typing into the blanks and checking the appropriate boxes.

Patient Name *(Last, First, Middle)*

Date of Birth

Social Security Number

Patient's Address

City, State

ZIP Code

Phone Number

Notice to Patient: Information in your medical record that you have or may have a communicable or venereal disease is made confidential by law and cannot be released without your permission except in limited circumstances including release to persons who have had risk exposures, release pursuant to an order of the court or the Department of Health, release among health care providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

The information authorized for release may include records concerning a communicable or venereal disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus (HIV), also known as acquired immune deficiency syndrome (AIDS).

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I hereby authorize Cancer Treatment Centers of America® (CTCA) to obtain information from:

All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment and VA health care facilities.

Information released from providers listed above should be sent to CTCA®:

- ☐ **Eastern Regional Med. Ctr. (Philadelphia)**
- ☐ **Southwestern Regional Med. Ctr. (Tulsa)**
- ☐ **Midwestern Regional Med. Ctr. (Chicago)**
- ☐ **Western Regional Med. Ctr. (Phoenix)**
- ☐ **Southeastern Regional Med. Ctr. (Atlanta)**

This consent is allowed to be acted upon up to one year from the date of signature, unless a shorter time is specified by the patient or their representative. This authorization will remain in effect until the ______ day of ______________, 20____ or until the following event occurs: ______________________________

______________________________.

I understand this authorization is subject to revocation by me at any time except to the extent that action has already been taken in reliance on it. With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity, and release CTCA, its agents and employees from any liability in connection with the release of information contained therein. I understand that I may at any time make a written request to inspect and/or obtain a copy of my health information and that CTCA will, within 45 days of receiving such written request, either grant the request and contact me to arrange for a convenient time to inspect and/or copy my health information or provide me with a written denial of the request that states the basis for the denial, my review rights (if any) and instructions as to how and to whom I may register a complaint regarding the denial. I may contact the Privacy Office of the hospital I have checked above, by mail or by telephone, at the address and/or phone number provided on the instruction sheet of this form.

Specify information to be disclosed for treatment dates ____ to ____.
(MM/YY) (MM/YY)

The information disclosed will be limited to the following as marked:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Oncology Records
- ☐ Rehabilitation Notes
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Pathology Slides
- ☐ EEG
- ☐ EKG
- ☐ ER Reports
- ☐ Abstract of Chart
- ☐ Imaging Reports and Films
- ☐ Consultation
- ☐ Naturopathic Notes
- ☐ Medication Summary
- ☐ Laboratory Reports
- ☐ Chemotherapy Flowsheet
- ☐ Chemotherapy Records
- ☐ Radiation Therapy Records and Notes
- ☐ Other *(specify)* ______________ ______________

Highly Sensitive Information

By *initialing the blank* or *typing your initials* next to a category of highly sensitive information listed below, I specifically authorize the use and/or disclosure of the indicated category, if any such information exists:

_____ Mental Illness or Developmental Disability
_____ Psychotherapy Notes *(requires provider consent)*
_____ Substance Abuse or Diagnoses *(e.g., alcohol or drugs)*
_____ Genetic Testing
_____ Abuse of an Adult with Disability
_____ Sexual Assault
_____ Child Abuse and Neglect
_____ Sexually Transmitted Disease
_____ HIV/AIDS Testing or Treatment *(including if an HIV test was ordered, performed or reported regardless of the results)*

For the following purpose and that purpose only:

☐ Continued Treatment ☐ Personal ☐ Other *(specify)* ______________

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my protected health information. By my signature, I hereby knowingly and voluntarily authorize CTCA to use or disclose my health information in the manner as described above.

Patient Signature *(If patient unable to sign, indicate reason; e.g., is a minor or medically incapacitated)* Date

Parent/Guardian/Other Legal Representative *(Provide copy of legal document and specify relationship to patient)* Date

Witness *(Witness signature required for release of information about a mental illness)* Date