Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Instructions: Please answer these questions as accurately as possible. This will help your physician evaluate your illness. All information is confidential and will not be released without your written permission.

List of Chronic Medical Illnesses or Problems

Have you ever had any of the following?			Have you ever had any of the following?		
	Yes	No		Yes	No
Prior Cancers - Type	☐	☐	Kidney Failure	☐	☐
Angina	☐	☐	Kidney Stones	☐	☐
Heart Attacks	☐	☐	Cystitis or Bladder Infections	☐	☐
Heart Failure	☐	☐	Prostatitis (Men Only)	☐	☐
Heart Murmur	☐	☐	Arthritis	☐	☐
Irregular Heartbeat	☐	☐	Have you had more than 2 episodes within 3 years:	☐	☐
BPH/Enlarged Prostate	☐	☐	Elevated Cholesterol	☐	☐
Lupus	☐	☐	Stroke or Paralysis	☐	☐
Scleroderma	☐	☐	Asthma	☐	☐
Anemia	☐	☐	Tuberculosis	☐	☐
HIV or AIDS	☐	☐	Seizures or Epilepsy	☐	☐
Diabetes	☐	☐	Irritable Bowel Syndrome	☐	☐
Hemorrhoids	☐	☐	Thyroid Disease or Goiter	☐	☐
Rectal Bleeding	☐	☐	Glaucoma/Cataracts	☐	☐
Gallbladder Disease	☐	☐	Parkinson's Disease	☐	☐
Hepatitis or Liver Disease	☐	☐	Multiple Sclerosis	☐	☐
Pancreatitis	☐	☐	Other Neurologic Problems	☐	☐
Crohn's Disease	☐	☐	Skin Condition(s)	☐	☐
Colitis	☐	☐	Severe Anxiety	☐	☐
TURP (Men Only)	☐	☐	If Yes, date of TURP _____		
Diverticular Disease	☐	☐	If Yes, year of onset _____		
High Blood Pressure	☐	☐	If Yes, date of onset _____		
Chronic	☐	☐	Ulcers of Stomach or Small Intestine	☐	☐

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Bronchitis/Emphysema	☐	☐			
Other Collagen Vascular Disease	☐	☐	Blood Clots or Clotting Disorder	☐	☐
Other Urological Operations/Procedures	☐	☐	If Yes, please list in "surgeries" section below		
Hernia	☐	☐			
Which type?	☐ Inguinal		☐ None	☐ Hiatal	

Medical History:

	Yes	No
Do you have a pacemaker or internal defibrillator?	☐	☐
Have you ever had hip surgery?	☐	☐

Surgeries, Procedures & Hospitalizations:

Type of Procedures or Hospitalizations	Where	Year

Important: Prior Cancer Treatments

Have you ever had any radiation (ex: seeds, cobalt, external radiation, radioisotopes including treatment for birthmarks, acne, cancer etc.?)

☐ Yes ☐ No

If Yes, where (name of institution) was this performed, what for, and when?

Have you ever received Chemotherapy? ☐ Yes ☐ No

If Yes, what drugs and when?

_____

_____

_____

_____

_____

_____

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Have you received hormone therapy for cancer? ☐ Yes ☐ No If Yes, what drugs (i.e. Tamoxifen, Femara, Lupron, Casodex)?	
Hormone Therapy Name/Dose/Frequency	**Date**

For Women: (Gynecological History):

Menarche (First Menstrual Period) (Age):	Last Menstrual Period (Date):	
How many days does the period usually last	Age at menopause:	
Are you or could you be pregnant?	☐ Yes ☐ No	Age at first pregnancy?
Pregnancies (Number):	Miscarriage (Number):	Deliveries (Number):
Are you currently on Birth Control:	☐ Yes ☐ No	If yes, what?
Did you ever take hormones (i.e., estrogen, birth control pills, androgens, etc.)?	☐ Yes ☐ No	If yes, how long?

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Medications

List the medications you are presently taking, including OTC, Vitamins and Supplements:			
Prescription	**Dosage**	**Frequency**	**For What?**

Allergies (Drug, Food, Iodine etc.):

Do you have any allergies? ☐ Yes ☐ No
If Yes, what are you allergic to and what type of reaction do you get?

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Family History:

Relation	Age	Medical Problems	If Deceased, Age and Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Comments:			

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced/Separated ☐ Widowed ☐ Partnered

Spouse/Partner's Name: _____

Patient Occupation: _____

Work Situation: ☐ Full Time ☐ Part Time ☐ Medical Leave ☐ Disability ☐ Retired

Did you ever work in an occupation that involved exposure to cancer causing chemicals, fumes, or other carcinogens? ☐ Yes ☐ No

What: _____ For how many years? _____

Living Situation: ☐ House ☐ Apartment ☐ Mobile Home Who lives with you?_____

Transportation: ☐ Able to drive self ☐ Driver required

Do you follow any special diet? ☐ Regular ☐ Vegan/Vegetarian ☐ Renal ☐ Diabetic

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

REVIEW OF SYSTEMS

Please check any of the following symptoms that you are currently experiencing. If you do not have any of the listed symptoms in each section, please check [NONE) at the top of each section.

GENERAL/CONSTITUTIONAL: **If none of the following apply, check: NONE** ☐

☐ Loss of Appetite ☐ Fatigue ☐ Fever ☐ Night Sweat

☐ Chills/Rigors/Tremors ☐ Problems Sleeping ☐ Dizziness

☐ Weight Loss/Change: If yes, #lbs pounds over _____ for _____ months. Intentional? ☐ Yes ☐ No

EYES: **If none of the following apply check: NONE** ☐

☐ Blurred Vision ☐ Double Vision ☐ Increased Tearing ☐ Night Blindness

☐ Sensitivity to Light ☐ Visual Difficulties

HEAD & NECK (ENTM): **If none of the following apply, check: NONE** ☐

☐ Difficulty Swallowing ☐ Ear pain ☐ Nose Bleeds ☐ Painful Swallowing

☐ Difficulty Hearing ☐ Mouth Dryness ☐ Bleeding in Mouth ☐ Ear Infections

☐ Sinusitis ☐ Sputum Production ☐ Mouth Sores ☐ Taste Alterations

☐ Ringing in the Ears ☐ Masses or Lumps

SKIN: **If none of the following apply check: NONE** ☐

☐ Hair Loss ☐ Blisters ☐ Bruising ☐ Dry Skin

☐ Facial Burning ☐ Nail Changes ☐ Sensitivity to Sun ☐ Itching

☐ Rash ☐ Hives

BREAST: **If none of the following apply check: NONE** ☐

☐ Lump or Mass in Breast ☐ Nipple Discharge ☐ Nipple Inversion ☐ Pain in Breast

CARDIOVASCULAR: **If none of the following apply check: NONE** ☐

☐ Irregular Heartbeat ☐ Chest Pain ☐ Shortness of Breath ☐ Edema/Swelling of Feet

☐ Sleep Sitting or Propped Up ☐ Palpitations

RESPIRATORY: If **none of the following apply check: NONE** ☐

☐ Cough ☐ Cough Up Blood: How Long?_____ ☐ Cough Up Sputum: Color?

☐ Hiccoughs ☐ Difficult/Painful Breathing ☐ Wheezing ☐ Chest Wall Pain

Are you able to lie flat? ☐ Yes ☐ No Oxygen Use _____L/min

Shortness of Breath on Exertion:☐ Yes ☐ No

What Activity causes or makes it worse? _____

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

GASTROINTESTINAL: **If none of the following apply check: NONE** ☐

☐ Abdominal Pain Cramping ☐ Change in Bowel Habits ☐ Constipation ☐ Diarrhea

☐ Heartburn/Dyspepsia ☐ Vomiting Blood ☐ Symptomatic Hemorrhoids ☐ Nausea

☐ Bloody Stools/ Black Stools/GI Bleeding ☐ Satiety/Feel Full Quickly ☐ Vomiting

GENITOURINARY: **If none of the following apply check: NONE** ☐

☐ Pain or Burning on Urination ☐ Frequent Urination ☐ Blood in Urine ☐ Impotence

☐ Leakage or Loss of Bladder Control ☐ Get up at Night to Urinate: How Often? _____

☐ Kidney Stones ☐ Urgent Urination ☐ Change in Sexual Function

MUSCULO-SKELETAL: **If none of the following apply check: NONE** ☐

☐ Arthritis ☐ Bone Pain ☐ Painful Joints ☐ Weak Muscles

☐ Decreased Range of Motion

NEUROLOGIC: **If none of the following apply check: NONE** ☐

☐ Disorientation ☐ Dizziness ☐ Gait Changes ☐ Frequent Headaches

☐ Difficulty Sleeping ☐ Memory Loss ☐ Numbness or Tingling: Where? _____

Weakness in Part of Body: Where? _____ ☐ Seizure ☐ Sensory Problems

☐ Stroke ☐ Claustrophobia

PSYCHIATRIC: **If none of the following apply check: NONE** ☐

☐ Delusions ☐ Hallucinations ☐ Depression ☐ Mood Swings

☐ Change in Personality

If you check yes to any of these, how long have you had these problems? _____

Have you seen other doctors for these problems? _____

ENDOCRINE: **If none of the following apply check: NONE** ☐

☐ Diabetes ☐ Hot Flashes ☐ Thyroid Disease

HEMATOLOGICAL/LLYMPHATIC: **If none of the following apply, check: NONE** ☐

☐ Excessive Bruising ☐ Irregularities ☐ Swollen Lymph Glands

OB-GYN (For Women): **If none of the following apply check: NONE** ☐

☐ Unusual Vaginal Bleeding ☐ Unusual Vaginal Discharge ☐ Painful/Difficult Intercourse

☐ Vaginal Spotting

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

American Urological Association (AUA) Questionnaire on Urinary Function

Name _____ **Date** _____

Implant# _____ ☐PRE ☐ IMP ☐ XRT ☐ FU (Months after implant) _____

	Not at all	Less than 1 t ime in 5	Less than half the time	About half of the time	More than half the time	Almost always	Your Score
1) Incomplete Emptying Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating'?	*0*	*1*	*2*	*3*	*4*	*5*	
2) Frequency Over the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	*0*	*1*	*2*	*3*	*4*	*5*	
3) Intermittency Over the past month or so, how often have you found that you stopped and started again several times when you urinated?	*0*	*1*	*2*	*3*	*4*	*5*	
4) Urgency Over the past month or so, how often have you found it difficult to postpone urination?	*0*	*1*	*2*	*3*	*4*	*5*	
5) Weak stream Over the past month or so, how often have you had a weak urinary stream?	*0*	*1*	*2*	*3*	*4*	*5*	
6) Straining Over the past month or so, how often have you had to push or strain to begin urination'?	*0*	*1*	*2*	*3*	*4*	*5*	
7) Nocturia Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning'?	*0*	*1*	*2*	*3*	*4*	*5*	
From the American Urological Association (AUA) Symptom Index for BPH				Total your score here. Total Symptom Score= Sum of Questions 1 to 7 =			

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

SEXUAL HEALTH INVENTORY FOR MEN

PATIENT NAME: _____ **DATE OF EVALUATION:** _____

Implant#_____ ☐PRE ☐ IMP ☐ XRT ☐ FU (Months after implant)_____

Please answer these six questions on erections using ONLY ONE of the possible answers under each question.
If you are ***not*** taking an **Erectile Dysfunction (ED)** drug, please put your answers in the "Natural" column labeled **"A"**.
If you ***are*** taking an **Erectile Dysfunction (ED)** drug. please answer **BOTH** according to how your erections are **WITHOUT** the ED drug in column **"A"** (Natural) and **WITH** the ED drug in column **"B".**

Are you currently taking an ED Drug? ❍ **No** ❍ **Yes** ❍ **Viagra** ❍ ***Cialis*** ❍ ***Levitra***

If yes, **please choose dosage: Viagra:** ❍ **25** ❍ **50** ❍ **100** **Cialis:** ❍ **5** ❍ **10** ❍ **20** **Levitra:** ❍ **5** ❍ **10** ❍ **20**

	"A" Natural (no ED)	"B" With ED Drug
1. How do you rate your confidence that you could get and keep an erection?		
1. Very low 2. Low 3. Moderate 4. High 5. Very High	A.	B.
2. When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?		
0. No sexual activity 1. Almost never or never 2. A few times (much less than half of the time) 3.. Sometimes (about half the time) 4. Most times (much more than half) 5. Almost always or always	A.	B.
3. During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?		
0. Did not attempt intercourse 1. Almost never or never 2. A few times (much less than half of the time) 3. Sometimes (about half the time) 4. Most times (much more than half) 5. Almost always or always	A.	B.
4. During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse?		
0. Did not attempt intercourse 1. Extremely Difficult 2. Very Difficult 3. Difficult 4. Slightly Difficult 5. Not Difficult	A.	B.
5. When you attempted sexual intercourse, how often was it satisfactory for you?		
0. Did not attempt intercourse 1. Almost never or never 2. A few times (much less than half of the time) 3. Sometimes (about half the time) 4. Most times (much more than half) 5.Almost always or always	A.	B.
Score: Add Q1-Q5 Here:	A.	B.
6. How often do you have sexual intercourse with a partner?		
1. I am capable of satisfactory sexual intercourse, but I have not attempted in the last six months or since last filling out this form. 2. Not at all, I cannot get an erection. 3. Less than once a month 4. 1 to 3 times a month 5. 1 time a week 6. 2 to 3 times a week 7. More than 4 times a week	A.	B.

Patient Reported History

Patient Name:_____ Form Completion Date:_____.

Medical Record #_____

Date:_____ Patient RT#:_____

First Name MI Last Name Date of Birth Age

Address Apt# City State Zip County of Residence

❍ Home Phone ❍Work Phone ❍ Cell Phone ❍ Secure e-mail

Check your preferred method of contact ❍ Secure e-mail ❍ Mail (to address above)

Attention: We will use all phone numbers listed above to contact you as necessary for treatment and payment purposes unless you place a restriction on the use of these numbers in writing.

Social Security # (*optional*)_____**Sex**: ❍Male ❍Female

Preferred Language:_____**Marital Status**: ❍Single ❍Married ❍Widow ❍Divorced

Ethnicity: ❍Hispanic/Latino ❍Not Hispanic/Latino ❍Do not want to provide ❍Do not know

Race: ❍American Indian or Alaska Native ❍Asian ❍Black or African American ❍White ❍Native Hawaiian or Pacific Islander

Employed: ❍Yes ❍No Retired ❍No ❍Yes __Disabled: ❍No ❍Yes _____.
Date Date

Employer:_____Occupation:_____.

Are you currently staying in a SNF, Convalescent Home or enrolled in Hospice ❍*Yes* ❍*No*

NOTE: If NO, Patient or Caregiver must immediately notify staff if Patient is admitted to a hospital SNF, Convalescent Home or Hospice.

*Name of Facility*_____ *Phone* _____.

Address _____ *City*_____ *State*_____*Zip*_____.

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

INSURANCE INFORMATION

Primary Insurance Medical Group (HMO) ID# Group#

Name/Relation of Policy Holder Social Security # of Policyholder Date of Birth of Policyholder

Secondary Insurance Medical Group (HMO) ID# Group#

Name/Relation of Policy Holder Social Security# of Policyholder Date of Birth of Policyholder

Primary Care Physician Phone

Referring Physician Phone

EMERGENCY CONTACT

Name Phone Relationship

PHARMACY INFORMATION

Pharmacy Name: _____ Phone Number_____.

Patient/Guardian Signature _____ Date ___/___/____.

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Physician List

Patient Name: _____ Date: _____

Please list the names, addresses and phone numbers of physicians that you are seeing. If you do not have all the information with you at the time of your visit, please call us when you get home. This information is very important so that we can inform your physicians of your progress.

Primary Physician: _____
Address: _____
_____
Phone: _____

Referring Physician: _____
Address: _____
_____
Phone: _____

Medical Oncologist: _____
Address: _____
_____
Phone: _____

_____
Surgeon: _____
Address: _____
_____
Phone: _____

_____
OB/GYN: _____
Address: _____
_____
Phone: _____

_____
Other Physician: _____
Address: _____

Phone: _____

Patient Reported History

Patient Name:_____ Form Completion Date:_____.

Medical Record #_____

Authorization for Release of PHI to Care Givers

(For individuals directly involved in the patient's care or payment for care)

I, _____ _, authorize the following persons(s) (spouse, partner, sibling, child, friend, etc.) access to my private health information (PHI).

Name (Printed) _____.

Relationship _____.

Date if Birth ____/____/____ Phone Number_____.

Name (Printed) _____.

Relationship _____.

Date if Birth ____/____/____ Phone Number_____.

Name (Printed) _____.

Relationship _____.

Date if Birth ____/____/____ Phone Number_____.

I understand that these persons are authorized to access my information until that authorization is revoked. Authorization can be revoked verbally or in writing at any time by me (patient) or an appointed Durable Health Care Power of Attorney.

Signature of Patient _____

Name (Printed) _____Date _____

Personal Representative

I,_____, attest that I can act on behalf of _____(patient) for purposes of treatment authorization and or Use and Disclosure of the patients PHI through rights afforded to me by the state. I will provide all legal documentation required to support the above statement. (Please attach legal documentation to this form).

Examples:

- Durable Power of Attorney for Health Care
- Health Care Proxy
- Court-Appointed Guardian
- Letters of Testamentary/Administration

Signature _____

Name (Printed) _____ Date _____

HI-500-004.00IFI - Authorization For Release of PHI to Care Givers

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Advanced Care Planning

We are working to increase awareness of "Advanced Care Planning (ACP)" with all of our patients. Do you currently have a Living Will or a Power of Attorney for Healthcare Form?

☐ Yes ☐ No
☐ Patient Declined

*If you answered "Yes," please be sure to provide a copy of your ACP documents and/or the full name of the Surrogate Decision Maker below, along with these completed forms.

Do you have a Healthcare Surrogate Decision Maker?

☐ Yes ☐ No
☐ Patient Declined

*If you answered "Yes," please provide the full name and contact number of the Healthcare Surrogate Decision Maker, as well as the relationship to the patient below, along with these completed forms.

Healthcare Surrogate Decision Maker: _____ Date: _____
(Please Print Full Name)

Healthcare Surrogate Decision Maker Contact Number: _____

Relationship to Patient: _____

Assignment of Benefits

Medicare Lifetime Assignment of Benefits

I request that payment of authorized Medicare benefits be made to me or on my behalf to **Radiotherapy Clinics of Georgia** (the "Provider") for any services furnished me by the Provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian Signature: _____ _____ _____ Date:____ _ _____ _

Medigap (Medicare supplemental insurance) Assignment of Benefits

I request payment of authorized Medigap benefits be made to the Provider and also authorize any holder of medical information about me to release to the Medigap insurer listed below any information needed to determine benefits payable for services from the Provider.

Medigap Insurance Name: _____

Patient/Guardian Signature: _____ Date: _____

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

General Assig nment of Benefits

1 request that payment of authorized insurance benefits be made on my behalf to the Provider for any equipment or services provided to me by those organizations. I authorize the release of any medical or other information to my insurance company in order to determine the benefits payable for the services rendered by the Provider.

I understand that I am financially responsible to the Provider for any charges not covered by my health benefits. It is my responsibility to notify the Provider of any changes in my healthcare coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill *if* the submitted claims or any part of them are denied for payment. I accept financial responsibility for payment for all services or products received.

Patient/Guardian Signature_____ Date: _____

Receipt of HIPAA Patient Privacy Rights Notification

My signature below indicates that I have received the HIPAA Patient Privacy Rights Notification and that I have been made aware of my privacy rights and how I may exercise those rights. I understand that all contact phone numbers listed on the Patient Registration Form may be used to contact me for treatment or payment purposes unless I submit a written request to restrict the use of any/all contact phone numbers listed.

Patient/Guardian Signature: _____ Date: _____

Fundraising Communications Opt-Out

By checking the box below, I indicate that I do not want to receive any fundraising communications from my Provider.

◯ I do not want to receive any fundraising communications

Patient/Guardian Signature_____ Date: _____

HI-500-003 001F2 Assignment of Benefits

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

Radiotherapy Clinics of Georgia
A Partner In The US Oncology Network

2349 Lawrenceville Highway
Decatur. GA 30033
T • 404-320-1550
F, 404-728-1081
www.t<og.com

PATHOLOGY SLIDES RELEASE

I **authorize Radiotherapy Clinics of Georgia to obtain ALL my prostate pathology slides from:**

Laboratory name: _____
Address: _____
_____
City/State/Zip: _____
Phone number: _____
Fax number: _____

for review by: Ameripath, Quest Diagnostics

I authorize the laboratory listed above, to accept a photocopy or facsimile of this document as my official consent to release my records.

_____
Signature of Patient or legal Guardian

_____ ____/____/____
Patient's printed name Patient's Date of Birth

Date_____

Please send ALL pathology slides to: Pathology Slides Coordinator, Radiotherapy Clinics of Georgia, 2349 Lawrenceville Highway, Decatur, GA 30033-3143

I understand that my insurance company will be billed by Ameripath, Quest Diagnostics for this pathology review and that any balance due after insurance will be my responsibility.

X_____
Signature of Patient or legal Guardian

_____ ____/____/____
Patient's printed name; Patient's Date of Birth

Date_____

Patient Reported History

Patient Name:_____ Form Completion Date:_____.____

Medical Record #_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information is being requested for: **(Please Print Clearly)**

Last Name MI First Name Maiden/Other Name Date of Birth

Phone# Address City State Zip

Date(s) of service requested: _____
From To

Release the medical information from:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Disclose the medical information to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Requested medical information authorized to be released: (check items authorized to be released)

- ❑ Consult/H&P
- ❑ OP Report/Procedure Report
- ❑ Follow-up notes
- ❑ Progress Notes
- ❑ Discharge Summary
- ❑ Weekly CBC reports
- ❑ PSA scores
- ❑ All Labs
- ❑ Tumor Markers
- ❑ Pathology Reports
- ❑ Pathology Slides
- ❑ EKG
- ❑ All CT scans /X-rays /Ultrasound
- ❑ Mammograms
- ❑ Radiotherapy Treatment Records
- ❑ Entire Chart
- ❑ Chemotherapy Flow Sheet
- ❑ Other _____

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under law. My check mark(s) below indicate(s) that I permit information of this type, if it exists, to be released. I understand that **IF** I do check the box, _____ will release such information about me if it exists.

- □ HIV/AIDS infection
- □ Treatment for alcohol and/or drug abuse
- □ Sexually transmitted diseases
- □ Genetic
- □ Mental Health
- □ Other _____

Note: This authorization is for treatment, payment, or healthcare operations purposes unless otherwise described in the space provided below. While every attempt will be made to protect the privacy of your health information, please note that release of your health information to an authorized person or organization could be the subject of re-disclosure by the recipient and therefore no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) or other federal or state laws. This authorization will expire within 365 days unless you specify otherwise. You have the right to revoke this authorization in writing except to the extent that we have released information prior to a revocation. To revoke authorization, send written request to: Radiotherapy Clinics of Georgia, Director of Health Information Management, 2349 Lawrenceville Highway, Decatur, GA 30033-3143. You have the right to request your records be provided in electronic format if available. I understand that my health information is protected by federal and state privacy laws and cannot be disclosed without my written consent except as specifically provided by law.
I understand that I may refuse to sign this authorization and that my refusal to sign will not *affect* my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here below.

Patient Reported History

Patient Name:_____ Form Completion Date:_____

Medical Record #_____

_____

_____

_____ _____ __/__/____
Signature of Patient or Representative* Relationship to Patient* Date

_____ __/__/____
Signature of Parent/Guardian (minors ages 0-17) Date

* **Supporting documentation must be provided**

Attention Staff: This form may only be completed when there is a need to request medical records/films and must be completed in full for each entity from which you are releasing records or to which you are sending records. Under HIPAA, this form is not necessary in order to share or obtain medical information for treatment or payment purposes of the current medical illness. This form is only valid if completely filled out.

HI-500-009.001F1 -Authorization to Release Medical Information Revised 2/2021