HONORHEALTH®

Virginia G. Piper Cancer Care Network

Welcome to the HonorHealth Virginia G. Piper Cancer Care Network. Our valley-wide locations put you, the patient, at the center of everything we do. Our team of specialists are committed to providing you with outstanding coordinated care.

**Prior to your visit**

Before your appointment, we ask that you print and fill out the attached New Patient Packet. We realize that you may have already provided similar information to other HonorHealth providers in the past and understand that this may seem redundant. However, with health histories and circumstances changing continually, it is important for our team to have your most recent and updated information to provide you with the finest personalized care.

**MyChart App**

To simplify your healthcare, we strongly encourage you to download or sign up for the MyChart App. MyChart is a free, easy-to-use, secure website that gives you access to your health information quickly and conveniently from your computer, smartphone or tablet. Visit HonorHealth.com/mychart to learn more about the advantages of MyChart and to get instructions on how to sign up.

If you have questions, please do not hesitate to talk to your physician. You may also call 855-485-HOPE (4673) for additional information and support.

It is an honor to serve you during this time.

HONORHEALTH

Virginia G. Piper Cancer Care Network

# PATIENT REGISTRATION

**Hematology/Medical and GYN Oncology Division**

**Patient Full Name:** _____ **Birth Date:** _____

**SSN:**_____ **Email Address**:_____ **Gender**: ☐ M ☐ F

**Home Address**:_____ _____
Street City State Zip

**Mailing Address:**_____ _____
Street City State Zip

**Home Phone**:_____ **Work phone**:_____

**Mobile Phone:** _____ **Mobile Phone Provider**:_____

**Notification preference**? ☐ Mobile Phone ☐ e-Mail ☐ Text Message ☐ Home Phone

**May we leave a message (circle)**? Yes or No **Please circle preference for voice message**: Home or Mobile Phone

**Mothers Maiden Name**: _____

**Emergency Contact**:_____ **Relationship to Patient**: _____

**Home Phone**:_____ **Mobile Phone**: _____

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

**Ethnicity**: ☐ Hispanic or Latino ☐ Not Hispanic or Latino (requested demographic question for the State of AZ)

**Race**: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ White/Caucasian
☐ Native Hawaiian ☐ Other Pacific Islander ☐Other: _____

**Religion Preference:** _____

**Preferred Language**: ☐ English ☐ Spanish ☐ French ☐ Chinese ☐ Other:_____

**Visually Impaired:** ☐ Yes ☐ No

**Patient Employer**:_____ **Occupation:** _____

**Primary Insurance**:_____ **Subscriber Name**:_____

**Subscriber Date of Birth**:_____ **Relationship to Subscriber**:_____

**ID#** _____ **Group#:** _____

**Secondary Insurance**:_____ **Subscriber Name**: _____

**Subscriber Date of Birth:**_____ **Relationship to Subscriber**:_____

**ID#** _____ **Group#**:_____

**Do you have a Living Will?** ☐ Yes ☐ No **If yes, please provide a copy for our records**
**Do you have a DNR?** ☐ Yes ☐ No **If yes, please provide a copy for our records**

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**Virginia G. Piper Cancer Care Network**

# PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

Visit Date: _____

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ When did the problem begin: _____

REFERRING DOCTOR (NAME, ADDRESS, PHONE #) _____

PRIMARY DOCTOR (NAME, ADDRESS, PHONE #) _____

PATIENT'S PHARMACY (NAME, ADDRESS, PHONE #) _____

MEDICINE/FOOD/LATEX/CONTRAST ALLERGIES:___ NONE or LIST IF ANY: _____

**CURRENT MEDICATIONS** (name and dosage) OR **CHECK HERE** _____ if Med List is attached

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

**CHRONIC CONDITIONS/PAST MEDICAL HISTORY: Have you ever had any of the following?** (circle all that apply)

High Blood Pressure
Diabetes – If yes, type: _____
Stroke/TIA
Lupus
Heart Failure
Vascular Disease
Heart Disease
Heart attack
Seizures
Colitis/Diverticulitis
Anxiety
Depression
COPD
Hyperthyroidism
Abnormal Heart Rhythm
Atrial Fibrillation
Heart Murmur
Neuropathy
Hypothyroidism
Aneurysm
Blood Clots
Genetic Disorder Type:_____
STDs - If yes, type: _____
HIV
Other:_____

**Have you had any of the following tests?**

| | Yes | When and Where |
|---|---|---|
| Abnormal biopsy | ☐ | |
| CT Scan | ☐ | |
| MRI Scan | ☐ | |
| PET Scan | ☐ | |
| Mammogram | ☐ | |
| Colonoscopy | ☐ | |
| PAP Smear | ☐ | |
| Endoscopy | ☐ | |
| Blood Transfusions | ☐ | |
| Bone Mineral Density Test (DEXA) | ☐ | |

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# PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

Patient Name: _____ Date of Birth: _____

**PATIENT SURGICAL HISTORY** (NAME AND YEAR)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

**Any implanted devices or metal (pacemakers, pumps, etc.) Please circle: YES NO**

**VACCINES:** Have you had the following vaccines:

**PNEUMONIA** ☐ NO ☐ YES, Date _____ **TETANUS** ☐ NO ☐ YES, Date _____

**SHINGLES** ☐ NO ☐ YES, Date _____ **FLU VACCINE** ☐ NO ☐ YES, Date _____

**OTHER VACCINE** ☐ NO ☐ YES, Date _____

**TOBACCO USE:** ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **ALCOHOL USE:** ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY

**CAFFEINE** (Coffee, tea, energy drinks) ☐ NEVER ☐ RARELY ☐ DAILY

**DRUG USE:** ☐ NEVER ☐ CURRENT ☐ PREVIOUSLY **EXPOSURE TO HIV:** ☐ NO ☐ YES

## SOCIAL HISTORY: Lifestyle

Highest Education level: _____

With whom do you live? _____

Do you exercise? ☐ Never ☐ Sometimes ☐ 30 minutes, 3x/week or more

Have you experienced 10 lbs weight loss or gain in past 3 months? ☐ NO ☐ YES

## SOCIAL HISTORY: Mobility

Do you have problems with mobility (use a wheelchair, cane, or walker)? ☐ NO ☐ YES; if yes describe issue and/or device used: _____

Have you had a fall in the past year? ☐ NO ☐ YES

Do you feel unsteady? ☐ NO ☐ YES

**FAMILY MEDICAL HISTORY**

| | **ALIVE AND WELL?** | **DISEASE** | **IF DECEASED, CAUSE AND AGE OF DEATH** |
|---|---|---|---|
| FATHER | ☐ NO ☐ YES | _____ | _____ |
| MOTHER | ☐ NO ☐ YES | _____ | _____ |

Any history of cancer in the family? _____

Are there any religious considerations that would keep you from receiving blood products? ☐ NO ☐ YES

**Women only ---**

**Age menstrual cycle began:** _____ **Menopause Age:** _____ **Number of Pregnancies:** _____ **Live Births:** _____

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# PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

| CONSTITUTIONAL SYMPTOMS | | |
|---|---|---|
| ACTIVITY CHANGE | NO | YES |
| APPETITE CHANGE | NO | YES |
| CHILLS | NO | YES |
| DIAPHORESIS (SWEATING) | NO | YES |
| FATIGUE (WEAKNESS) | NO | YES |
| FEVER | NO | YES |
| NIGHT SWEATS | NO | YES |
| PAIN | NO | YES |
| RIGORS (CHILLS) | NO | YES |
| UNEXPECTED WEIGHT CHANGE | NO | YES |
| **HEENT** | | |
| CONGESTION | NO | YES |
| DENTAL PROBLEM | NO | YES |
| DRY MOUTH | NO | YES |
| EAR PAIN | NO | YES |
| FACIAL SWELLING | NO | YES |
| HAIR LOSS | NO | YES |
| HEARING LOSS | NO | YES |
| MOUTH SORES | NO | YES |
| NOSEBLEEDS | NO | YES |
| POSTNASAL DRIP | NO | YES |
| RHINORRHEA (RUNNY NOSE) | NO | YES |
| SINUS PRESSURE | NO | YES |
| SORE THROAT | NO | YES |
| TASTE CHANGES | NO | YES |
| THRUSH | NO | YES |
| TINNITUS (RINGING IN EARS) | NO | YES |
| TROUBLE SWALLOWING | NO | YES |
| VOICE CHANGE | NO | YES |
| **BREAST** | | |
| RIGHT INVERTED NIPPLE | NO | YES |
| RIGHT MASS | NO | YES |
| RIGHT NIPPLE DISCHARGE | NO | YES |
| RIGHT SKIN CHANGE | NO | YES |
| LEFT INVERTED NIPPLE | NO | YES |
| LEFT MASS | NO | YES |
| LEFT NIPPLE DISCHARGE | NO | YES |
| LEFT SKIN CHANGE | NO | YES |
| **EYES** | | |
| BLURRED VISION | NO | YES |
| DOUBLE VISION | NO | YES |
| EYE DISCHARGE | NO | YES |
| EYE ITCHING | NO | YES |
| EYE PAIN | NO | YES |

| EYES CONTINUED | | |
|---|---|---|
| EYE REDNESS (DRY EYES) | NO | YES |
| FLOATERS | NO | YES |
| PHOTOPHOBIA (SENSITIVITY TO LIGHT) | NO | YES |
| VISUAL DISTURBANCE | NO | YES |
| **RESPIRATORY** | | |
| DYSPNEA ON EXERTION (SHORTNESS OF BREATH ON EXERTION) | NO | YES |
| CHEST TIGHTNESS | NO | YES |
| CHOKING | NO | YES |
| COUGH | NO | YES |
| HEMOPTYSIS(COUGHING UP BLOOD) | NO | YES |
| SHORTNESS OF BREATH (DIFFICULTY BREATHING) | NO | YES |
| STRIDOR | NO | YES |
| WHEEZING (ASTHMA) | NO | YES |
| **CARDIOVASCULAR** | | |
| CHEST PAIN | NO | YES |
| LEG SWELLING | NO | YES |
| ORTHOPNEA | NO | YES |
| PALPITATIONS | NO | YES |
| PND(PAROXYSMAL NOCTURNAL DYSPNEA) | NO | YES |
| **GI** | | |
| ABDONIMAL DISTENTION | NO | YES |
| ABDOMINAL PAIN | NO | YES |
| ANAL BLEEDING | NO | YES |
| ASCITES (ABDOMINAL SWELLING) | NO | YES |
| BLOOD IN STOOL (BLACK STOOLS) | NO | YES |
| CONSTIPATION | NO | YES |
| DIARRHEA | NO | YES |
| EARLY SATIETY (FEELING FULL) | NO | YES |
| GERD/HEARTBURN | NO | YES |
| NAUSEA AND VOMITING | NO | YES |
| HERNIA | NO | YES |
| **ENDOCRINE** | | |
| COLD INTOLERANCE | NO | YES |
| DIABETES | NO | YES |
| HEAT INTOLERANCE | NO | YES |
| HOT FLASHES | NO | YES |
| POLYDIPSIA (GREAT THIRST) | NO | YES |
| POLYPHAGIA (EXCESSIVE EATING) | NO | YES |
| POLYURIA (EXCESSIVE URINATION) | NO | YES |
| PRE-DIABETES | NO | YES |
| **GU** | | |
| DYSURIA((PAIN/DIFFICULTY URINATING, HESITANCY) | NO | YES |
| FLANK PAIN | NO | YES |

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# PATIENT HEALTH HISTORY

Hematology/Medical Oncology and GYN Oncology Division

| GU CONTINUED | | | | PSYCHIATRIC | | |
|---|---|---|---|---|---|---|
| FREQUENT URINATION | NO | YES | | AGITATION | NO | YES |
| HEMATURIA (BLOOD IN URINE) | NO | YES | | BEHAVIOR PROBLEM | NO | YES |
| INCONTINENCE | NO | YES | | CONFUSION | NO | YES |
| NOCTURIA (FREQUENT URINATION AT NIGHT) | NO | YES | | DECREASED CONCENTRATION | NO | YES |
| PENILE DISCHARGE | NO | YES | | DEPRESSION | NO | YES |
| PENILE PAIN | NO | YES | | HALLUCINATIONS | NO | YES |
| PENILE SWELLING | NO | YES | | HYPERACTIVE | NO | YES |
| SCROTAL SWELLING | NO | YES | | NERVOUS/ANXIOUS (PANIC ATTACKS) | NO | YES |
| TESTICULAR PAIN | NO | YES | | SELF-INJURY | NO | YES |
| URGENCY TO URINATE | NO | YES | | SLEEP DISTURBANCE (INSOMNIA) | NO | YES |
| DECREASED URINE | NO | YES | | SUICIDAL IDEAS | NO | YES |
| **MUSCULOSKELETAL** | | | | HOMICIDAL IDEAS | NO | YES |
| ARTHRALGIAS (JOINT PAIN/BONE PAIN) | NO | YES | | **GYN** | | |
| BACK PAIN | NO | YES | | VAGINAL DISCHARGE | NO | YES |
| GAIT PROBLEM (WALKING ABNORMALLY) | NO | YES | | VAGINAL PAIN | NO | YES |
| JOINT SWELLING | NO | YES | | ABNORMAL BLEEDING | NO | YES |
| MYALGIAS (MUSCLE PAIN) | NO | YES | | | | |
| NECK PAIN | NO | YES | | | | |
| NECK STIFFNESS | NO | YES | | | | |
| **SKIN** | | | | | | |
| BLISTERING | NO | YES | | | | |
| CHANGING MOLES (SKIN LESIONS) | NO | YES | | | | |
| COLOR CHANGE | NO | YES | | | | |
| **ALLERGY/IMMUNE SYSTEM** | | | | | | |
| ENVIRONMENTAL/SEASONAL ALLERGIES | NO | YES | | | | |
| FOOD ALLERGIES | NO | YES | | | | |
| IMMUNOCOMPROMISED | NO | YES | | | | |
| CHEMICALS IN WORKPLACE | NO | YES | | | | |
| **NEUROLOGICAL** | | | | | | |
| PAINFUL NEUROPATHY | NO | YES | | | | |
| DIZZINESS | NO | YES | | | | |
| FACIAL ASYMMETRY | NO | YES | | | | |
| HEADACHES | NO | YES | | | | |
| LIGHT-HEADEDNESS | NO | YES | | | | |
| NUMBNESS/TINGLING | NO | YES | | | | |
| SEIZURES | NO | YES | | | | |
| SPEECH DIFFICULTY | NO | YES | | | | |
| SYNCOPE (ALTERED CONSCIOUSNESS) | NO | YES | | | | |
| TREMORS | NO | YES | | | | |
| WEAKNESS (PARALYSIS) | NO | YES | | | | |
| **HEMATOLOGIC** | | | | | | |
| ADENOPATHY (ENLARGED GLANDS) | NO | YES | | | | |
| BRUISES/BLEEDS EASILY | NO | YES | | | | |
| LYMPHEDEMA | NO | YES | | | | |
| PETECHIAE (BLEEDING UNDER SKIN) | NO | YES | | | | |
| PURPURA (RASH) | NO | YES | | | | |

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Virginia G. Piper Cancer Care Network

# HEREDITARY CANCER QUESTIONNAIRE

## Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Healthcare Provider: _____

**Instructions:** This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

**You and the following close blood relatives should be considered:** *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

## YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

| | CANCER | YOU AGE OF Diagnosis | PARENTS / SIBLINGS / CHILDREN | AGE OF Diagnosis | RELATIVES on your MOTHER'S SIDE | AGE OF Diagnosis | RELATIVES on your FATHER'S SIDE | AGE OF Diagnosis |
|---|---|---|---|---|---|---|---|---|
| ☑ **Y** ☐ **N** | *EXAMPLE BREAST CANCER* | 45 | —— | — | Aunt<br>Cousin | 45<br>51 | Grandmother | 53 |
| ☐ Y ☐ N | BREAST CANCER *(Female or Male)* | | | | | | | |
| ☐ Y ☐ N | OVARIAN CANCER *(Peritoneal/Fallopian Tube)* | | | | | | | |
| ☐ Y ☐ N | UTERINE (ENDOMETRIAL) CANCER | | | | | | | |
| ☐ Y ☐ N | COLON/RECTAL CANCER | | | | | | | |
| ☐ Y ☐ N | 10 or more LIFETIME GASTROINTESTINAL POLYPS *(Specify #)* | | | | | | | |
| ☐ Y ☐ N | OTHER CANCER(S) *(Specify cancer type)* | *Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid* | | | | | | |
| | | | | | | | | |

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had generic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

## Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any of the following:

| | | |
|---|---|---|
| ☐ | **Multiple**<br>A combination of cancers on the same side of the family: | o **2 or more:** breast / ovarian / prostate / pancreatic cancer<br>o **2 or more:** colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)<br>o **2 or more:** melanoma / pancreatic |
| ☐ | **Young**<br>Any 1 of the following at age **50 or younger:** | o Breast cancer<br>o Colorectal cancer<br>o Endometrial cancer |
| ☐ | **Rare**<br>Any 1 of these rare presentations at **any age:** | o Ovarian cancer<br>o Breast: Male breast cancer or Triple negative breast cancer<br>o Colorectal cancer with abnormal MSI/IHC, or MSI associated histology††<br>o Endometrial cancer with abnormal MSI/IHC<br>o 10 or more gastrointestinal polyps* |

†† Presence of tumor infiltrating lymphocytes, Chrohn's-lick lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern * Adenomatous type

*Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com*

## Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

**For Office Use only:** Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment _____

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## Virginia G. Piper Cancer Care Network

**Financial Counselor introduction**

At HonorHealth, the last thing we want is for your care to be frustrating. One of the ways we go beyond in caring for you is by meeting with you before you begin treatment. We'll discuss costs and options that can help alleviate any unexpected financial burden of your treatment. Our financial counselors will provide you with financial information regarding your insurance benefits (including details about your deductible status and out of pocket liability), as well as our payment policies. Determining your financial needs is not a one-time exercise –our financial counselors will meet with you and your family regularly to update any changes in your insurance coverage and reevaluate your financial resources throughout your treatment plan. Since you'll be receiving infusion treatments or injections in one of our clinics, here's how our team will support you:

- Once treatment is prescribed, our authorization team will verify the authorization requirements for your insurance. Our team members will initiate the authorization process to ensure your treatment can start in a timely manner.
- Our financial counselors will reach out to you before you start treatment to explain your insurance coverage, review your benefits and discuss your estimated financial responsibility based on information provided by your insurance.
- Once your authorization has been received, our team will continue to follow your treatment to ensure that any ongoing authorization needs are addressed.
- Our financial counselors will also review any possible financial assistance options from the manufacturer (if applicable), third-party foundations and any programs available through HonorHealth.
- If your physician orders a treatment that your insurance does not authorize, we'll work with the pharmaceutical company to apply for any applicable assistance program for you. Our counselors will work with you to complete the financial assistance forms and submit them for you.

Financial counselors are available from 7:30 a.m. to 3:30 p.m., Monday-Friday to answer your questions and discuss your treatment plan. You'll find their contact information in this packet.

Thank you for choosing HonorHealth. We look forward to going the extra mile for you.

*Laura Luna*

Manager-Patient Access
Laluna@honorhealth.com

Financial Counselors:

| | | | |
|---|---|---|---|
| *Celia Navarrette* | *Janna Underwood* | *Angelee Blasi* | *Andie Mariano* |
| *Leslie Thomas* | *Connie Obregon* | *Aurora Hensley* | *Christie Larman* |

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Virginia G. Piper
Cancer Care Network

# Notice of Privacy Practices and Communication Consent

This form is to identify who may or may not have access to oral communication in regards to the patient's protected health information while the patient is under treatment.

List the full name of family or friends with whom Virginia G. Piper Cancer Care Network can share your protected health information.

| Name | Phone Number | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

I _____ acknowledge that I have received a copy of Virginia G. Piper Cancer Care Network's Notice of Privacy Practices. I have identified who may or may not have access to my protected health information while under treatment at Virginia G. Piper Cancer Care Network.
I understand that this release is valid for the time frame of my diagnosis but may revoke authorization at any time by informing Virginia G. Piper Cancer Care Network specialists and my physician.

Print Name: _____ Date: _____

Patient Signature: _____

HONORHEALTH®

# AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

## PATIENT IDENTIFYING INFORMATION:

Patient Full Name:_____ Date of Birth: _____
Patient Address:_____ Home Phone: _____
City:_____ State:_____ Zip:_____ Work Phone: _____
E-Mail Address: _____

**Release Information To:**

HonorHealth Virginia G. Piper Cancer Care Network at FAX 480-882-5015

**Purpose of Request**: Continuing Care

**Specific Information to be Released:**

❑ Entire Medical Record, including physician services, clinical and diagnostic testing information, AIDS/HIV and other communicable disease information, genetic testing information, alcohol and/or drug abuse treatment information and psychiatric care reports.

❑ Specific Medical Information: Date(s) of Service: _____
- ❑ Pertinent Information* (includes H & P, discharge and other dictated reports, EKG, labs and radiology)
- ❑ Discharge Summary ❑ History & Physical ❑ Operative Report ❑ ER Report
- ❑ Consultation Report ❑ EKG ❑ Diagnostic Imaging Reports ❑ EEG ❑ Lab Results
- ❑ Pathology Reports ❑ Diagnostic Films (specify):_____ ❑ Family Practice Clinic
- ❑ Complete Records: Date of Visit_____ ❑ Other (specify): _____
- ❑ AIDS/HIV and other Communicable Diseases ❑ Genetic Testing Information
- ❑ Psychiatric Care Reports ❑ Alcohol and/or Drug Abuse Treatment

I understand that HonorHealth will not condition treatment on my signing this authorization. HonorHealth will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read HonorHealth's Notice of Privacy Practices.

To revoke my authorization, I must submit a written request to HonorHealth. Unless I *revoke* the authorization earlier, it will expire *3 years* from the date of signature. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be *re-disclosed* by the person or organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Relationship to Patient or Description or Authority to Act for Patient

DTHIMAUTH

**For Official Use Only: (Rev 02/16/2017)**
Acct#:_____ Delivery Method: _____
Initials:_____ Date:_____ Time: _____