Date: _____ Patient MRN#: _____

CANCER CARE CENTERS OF BREVARD | The US Oncology Network

_____ _____/_____/_____ _____

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 ❑ Mail (to address above) *Check your preferred method of contact*

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 # *:* _____ Sex: **M F** Marital Status: **S M W D**

Preferred Language: _____

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 □-Native Hawaiian or Pacific Islander □-White

Employed: **N Y** Retired: **N Y** _____ (Date) Disabled: **N Y** _____ (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

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 Name (Print): _____

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 **Choose Center Location** (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: _____

General Assignment of Benefits

I 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 Op-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: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Specified medical information is being requested for:

_____ _____ _____/_____/_____
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
____ Previous radiotherapy tx record
____ Entire chart
____ Chemotherapy Flow Sheet
____ Other_____

Note: While every attempt will be made to protect the privacy of your medical information, please note that release of your medical 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 90 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.

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

_____ _____/_____/_____
Signature of Parent/Guardian (minors age 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.

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 of Birth _____ Phone Number _____
Name (Printed) _____ Relationship _____ Date of Birth _____ Phone Number _____
Name (Printed) _____ Relationship _____ Date of 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 _____

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 Referral Source Form

(Please return completed form to front desk)

Patient Name:_____

Medical Record #: _____Form Completion Date: _____
(Office Only)

How did you hear about us? (check all that apply)

☐ Doctor: _____
Name

☐ Internet: _____
Blog, Website, Search

☐ Family/Friend: _____
Name (Optional)

☐ Magazine/Newspaper: _____
Name

☐ Prior Patient: _____
Name (Optional)

☐ Radio/TV: _____
Station/Program

☐ Insurance Company: _____

☐ Other:
_____
Billboard, Event, etc.

☐ Patient Navigation Center: _____

Patient Reported History

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

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

Anal CA		Gout		Skin Condition(s)	
Bladder CA		Heart Attacks		Stroke or Paralysis	
Brain CA		Heart Failure		Thyroid Disease or Goiter	
Breast CA		Heart Murmur		TIA/CVA	
Cervical CA		Hemorrhoids		Tuberculosis	
Colon CA		Hepatitis or Liver Disease		TURP (Men Only)	
Endometrial CA		Hernia		Ulcer/ GERD/ Diverticulosis	
Fallopian Tube CA		High Blood Pressure			
Lung CA		High Cholesterol			
Pancreatic CA/ GIST		HIV or AIDS			
Prostate CA		Hyper/Hypothyroidism			
Rectal CA		Hyperparathyroidism			
Renal CA		Hypertension			
Skin CA		Irregular Heart Beat			
Testicular CA		Irritable Bowel Syndrome			
Uterine CA		Kidney Failure			
Anemia		Kidney Stones			
Angina		Leukemia/Lymphoma			
Arthritis		Lupus			
Asthma		Migraines			
Atrial Fibrillation		Mitral Valve Prolapse			
Blood Clots or Clotting Disorder		Multiple Sclerosis			
BPH/Enlarged Prostate		Ostenopenia			
CAD		Osteoarthritis			
Choletithiasis		Osteoporosis			
Chronic Bronchitis/Emphysema		Ovarian Cancer			
Chronic Kidney Disease		Pancreatitis			
Chronic Rashes		Parkinson's Disease			
Cirrhosis		Peripheral Vascular Disease			
Colitis		Prostatitis (Men Only)			
COPD		Rectal Bleeding			
Crohn's Disease		Rheumatoid Arthritis			
Cystitis or Bladder Infections		Scleroderma			
Depression		Seizures or Epilepsy			
Diabetes		Severe Anxiety			
Diverticular Disease		Sexual/ Menstrual Dysfunction			
DJD		Other Collagen Vascular Disease			
Gallbladder Disease		Other Neurologic Problems			
Glaucoma/Cataracts		Other Urological Operations/Procedures			

Patient Name:_____ Medical Record #: _____

Form Completion Date: _____

Medical History:

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

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?

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

Patient Name:_____ Medical Record #: _____

Form Completion 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: ☐ None ☐ Yes, if so what _____

Did you ever take hormones (i.e. estrogen, birth control pills, androgens, etc.)? ☐ Yes ☐ No

If yes, how long? _____

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 Name:_____ Medical Record #: _____

Form Completion Date: _____

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

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 Cousin*	*45 61*	*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 genetic 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 one of the following:

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

††Presence of tumor infiltrating lymphocytes, Crohn's-like 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:_____

PATIENT REFERRAL FORM

Reset Form | Print Form | Submit Form | Use the TAB key to jump field to field

American Cancer Society

Notice to Patient

The American Cancer Society (ACS) offers services and information that could help you while you are dealing with your cancer. Please sign below if you agree that your doctor (or Health Care Provider) may share your information with the ACS. They will then contact you about the cancer information, services and resources that you request.

Patient Signature: _____ **Date:** _____

The ACS cares about your privacy and will protect and use your information only in accordance with its Privacy Policy, available at www.cancer.org. The ACS will use the information contained on this form to contact you about the services you have requested.

With your permission given below, the ACS may also use your information to contact you about other programs and services that may be of interest to you, to invite you to events in your community, and/or to tell you about volunteer or other support opportunities. If you would like to give the Society permission to contact you regarding these other opportunities, please initial here: _____ **(Patient Initials)**

If you have questions about your cancer, the ACS, its programs, services or privacy standards, or to change your contact preferences, please visit **www.cancer.org** or call **1-800-227-2345. The ACS is available 24 hours a day, 7 days a week.**

Provider Information

Healthcare Provider Name: | ACS ID:

Referral Contact Name: | Phone: ( ) –

Patient Information *(Minimum of one method of contact required). Information shared here will assist us in efficiently coordinating services.*

Patient Name: (required)

Primary Address: ☐ Home ☐ Business ☐ Other

City: *State:* *Zip Code:*

Primary Phone: ( ) – ☐ Home ☐ Cell ☐ Business

Alternate Phone: ( ) – ☐ Home ☐ Cell ☐ Business

Email: ☐ Personal ☐ Business

Date of Birth: *ex: MM/DD/YYYY* | Primary Language: ☐ English ☐ Spanish ☐ Other: *Please List*

Race: ☐ African American/Black ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic/Latino ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Two or more races ☐ Declined to Share ☐ Other: *Please List*

Gender: ☐ Female ☐ Male

Diagnosis

Date of Diagnosis: *ex: MM/DD/YYYY* | Type of Cancer: | ☐ Recurrence

Insurance: ☐ Medicaid ☐ Medicare ☐ Medicare + Medicaid ☐ Medicare + Private ☐ Military ☐ Private ☐ Uninsured ☐ Declined to Share

☐ Personal Health Manager Requested (Kit to organize your cancer and treatment information) ☐ English ☐ Spanish ☐ Other Language: *Please List*

Requested Services

Best Time to Call: *ex: 00:00* ☐ AM ☐ PM | OK to leave a message: ☐ Y ☐ N

☐ Transportation to cancer treatment | First Date Needed: *ex: MM/DD/YYYY* | Time: *ex: 00:00* ☐ AM ☐ PM

☐ Lodging during cancer treatment | First Date Needed: *ex: MM/DD/YYYY*

☐ One-on-one breast cancer support (Reach to Recovery) | Treatment Type: ☐ Early Support ☐ Lumpectomy ☐ Mastectomy ☐ Chemotherapy ☐ Radiation ☐ Advanced

☐ Classes to enhance appearance & self-esteem during treatment (Look Good Feel Better) | Skin Tone: ☐ Dark ☐ Extra Dark ☐ Light ☐ Medium

☐ Resources/Referrals for other needs: | ☐ Wig or head-coverings

Comments/Other information you would like us to know:

Healthcare Provider Instructions: The Notice above regarding American Cancer Society's use of information must be shared with the patient prior to submitting this form to the American Cancer Society. ACS will rely on Health Care Provider's submission of any Patient Referral Form as evidence that this Notice has been communicated to patient. Once completed, please fax form to **877-428-2862** or Email form to **SSBCREF@CANCER.ORG**

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights and your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Vantage Oncology, Attention: Director of Health Information Management, 53 Perimeter Center E., Suite 500, Atlanta, GA, 30346

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS.

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice including, but not limited to, our doctors and nurses may use or disclose your PHI in order to treat you or to assist others in your treatment. For example, we may disclose information to a referral physician. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment, services or refills or in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you, as long as our practice does not receive direct or indirect financial remuneration for such disclosure.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care or payment for your care, or who assists in taking care of you, including following your death. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

9. Public health reporting. Your health information may be disclosed to public health agencies as requires by law. For example, we are required to report certain communicable diseases to the state's public health department. We are also required to report your health information to state cancer registries.

10. Business Associates. We may disclose your health information to contractors, agents and other "business associates" who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company, or we may share your health information with an accounting firm or law firm that provides professional advice to us. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information. If our business associate discloses your health information to a subcontractor or vendor, the business associate will have a written contract to ensure that the subcontractor or vendor also protects the privacy of the information.

11. Proof of Immunization. We may disclose proof a child's immunization to a school, about a child who is a student or prospective student of the school, as required by State or other law, if a parent, guardian, other person acting in loco parentis, or an emancipated minor, authorizes us to do so, but we do not need written authorization.

12. Fundraising. We may use or disclose your demographic information, including, name, address, other contact information, age, gender, and date of birth, dates of health service information, department of service information, treating physician, outcome information, and health insurance status for fundraising purposes. With each fundraising communication made to you, you will have the opportunity to opt-out of receiving any further fundraising communications. We will also provide you with an opportunity to opt back in to receive such communications if you should choose to do so.

13. Other uses and disclosure require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision and has been relied upon by our practice.

D. USE AND DISCLOSURE OF YOUR PHI CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths, reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic

violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information

- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct, or regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process, or to identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your PHI is being used only for the research and (iii) the researcher will not remove any of your PHI from our practice; or (c) the PHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the PHI of the decedents.

8. Serious Threats to Health or Safety .Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement officials. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/ or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

We may **NOT** use or disclose your health information for the following purposes without a signed authorization:

Marketing. We may not disclose any of your health information for marketing purposes if our medical group will receive direct or indirect financial remuneration not reasonably related to our medical group's cost of making the communication.

Sale of Protected Health Information. We will not sell your protected health information to third parties. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where our medical group will only receive remuneration for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or part of our medical group, for a business associate or its subcontractor to perform health care functions on our medical group's behalf, or for other purposes as required and permitted by law.

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our medical group. You may also initiate the transfer of your records to another person by completing a written authorization form.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must submit a written request to the address provided in this notice, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. You have the right to request that your health information not be disclose to a health plan if you have paid for the services in full and the disclosure is not otherwise required by law. The request for restriction will only be applicable to that particular service. You will have to request a restriction for each service thereafter. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

In order to request a restriction in our use or disclosure of your PHI, you must submit a written request to the address provided in this notice**.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a paper or electronic copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit a written request to the address provided in this notice in order to inspect and/or obtain a paper or electronic copy of your PHI. If you would like an electronic copy of your health information, we will provide you a copy in electronic form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, you must submit a written request to the address provided in this notice. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment or operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit a written request to the address provided in this notice**.**

All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, you must submit a written request to the address provided in this notice. You can also obtain a copy of this Notice on our website.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice you must submit it in writing to the address provided in this notice**.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law, including HIV/AIDS, sexually transmitted diseases, genetic health information, mental or behavioral health, and drug/alcohol abuse treatment. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.

9. Right to Receive Notification of a Breach. You have the right to be notified if there is a probable compromise of your unsecured protected health information within sixty (60) days of the discovery of the breach. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

F. ELECTRONIC COMMUNICATION (EMAIL) & YOUR PHI

1. Electronic Communication with Patient. We will not share any PHI electronically through unsecure means. We do not make it a practice to transmit PHI via email unless an encryption system is in place between the sender and receiver. PHI will not be transmitted electronically in an unsecure manner. Before we will contact you through electronic communication (email) we must first receive authorization from you. You may grant authorization by filling out our *Email Request Form and our Important Information About Provider/Patient Email Form.* You may revoke this authorization at any time by submitting a written request to the address provided in this notice.

2. Request of Email Address. You may be asked to provide your email address for the sole purpose of sending you information about events, educational seminars, reminders about your questionnaire, etc. If you wish to not receive information from us via email you may decline to provide your email address. You may also ask to have your email address removed from our mailing list at any time by submitting a written request to the address provided in this notice.

Again, if you have any questions regarding this notice, your privacy rights, or our health information privacy policies, please contact:

Vantage Oncology
Attention: Director of Health Information Management
53 Perimeter Center E.
Suite 500
Atlanta, GA 30346
770-682-2099