Oncology Hematology Associates, A Division Of American Oncology Partners, P.A.
P: (417) 882-4880 | F: (417) 882-7843

Patient Name: _____ **DOB:**_____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Released – Covering the Periods of Health Care

From (date): _____ To (date): _____
From (date): _____ To (date): _____

Please Check Type of Information to be Released

❑ Complete Health Record	❑ Medication List	❑ Radiology Results	❑ Complete Billing Record
❑ New Patient Evaluation	❑ Chemo Flow Sheets	❑ Radiology CD/Films	❑ Other (specify) _____
❑ Progress Notes	❑ Lab Results	❑ Pathology Slides	_____
❑ Hospital Records	❑ Pathology Results	❑ Itemized Bill	_____

Purpose of Request

❑ Treatment or Consultation ❑ At Request of the Patient ❑ Billing or Claims Payment
❑ Other (specify) _____

I, the undersigned, authorize and request OHA to ❑ Release Information to ❑ Obtain Information from

Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome) testing and/or treatment, and/or sensitive information, I agree to its release. I understand that if I authorize the release of Drug & Alcohol Abuse treatment records that those records are protected by Federal Law. The Authorization for Release of Information form does not authoize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibit information disclosed from records protected by this law from being re-disclosed, even to the patient, without the specific written consent of the patient or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authoization by submitting a notice in writing to the facility Privacy Officer at 14543 Global Parkway, Suite 110, Fort Myers, FL 33913. Unless revoked, this authorization will expire on the following date or event _____, or one year from date of signature, unless otherwise specified.

Re-disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided solely to give information to a third party as specified under *Purpose of Request*. I can inspect or copy the protected health information to be used or disclosed. **I authorize Oncology Hematology Associates (OHA), a division of American Oncology Partners, P.A. (AOP), to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not patient: _____ Date: _____

Patient Name: _____ **DOB:**_____

PATIENT MEDICAL HISTORY FORM

Dear Patient,

Please return completed packet with signature pages to the front desk.

Age: _____ ❑ **Male** ❑ **Female** **SS#**:_____

Primary Address: _____

City:_____ State:_____ Zip: _____

Home Phone: ❑ Preferred (_____) _____

Cell Phone: ❑ Preferred (_____) _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

May we leave a message on your answering machine / voicemail? ❑ Yes ❑ No

Email Address: _____ May we email you? ❑ Yes ❑ No

Preferred Language: _____

Ethnicity: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino

Race: ❑ Native American or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White ❑ Other

Pharmacy Name: _____

Pharmacy Phone # and Cross Streets:_____

Advanced Directives:

Living Will ❑ Yes ❑ No **Durable Power of Attorney** ❑ Yes ❑ No **DNR** ❑ Yes ❑ No

Are you currently residing in a skilled nursing facility? ❑ Yes ❑ No

Name of facility:_____

Are you currently enrolled in hospice? ❑ Yes ❑ No

Name of hospice: _____

(Internal Use Only)

MRN#: _____

Patient Name: _____ **DOB:** _____

Primary Care Physician: _____Phone: _____

Referring Physician (if different): _____Phone: _____

Please list any additional Physicians you see: (Include Phone #):

_____Phone: _____

_____Phone: _____

_____Phone: _____

_____Phone: _____

Emergency Contact Name:

_____

Relationship: _____ Phone: (_____) _____

Employment Status:

❑ Employed/Self Employed ❑ Unemployed ❑ Retired ❑ Disabled

Occupation (or Former Occupation):_____

Name of Employer: _____ Work Phone: (_____) _____

Health Maintenance

Date of last bone density: _____

Date of last pap smear: _____ Have you ever had an abnormal PAP smear? ❑ Yes ❑ No

Date of last mammogram: _____ Was that mammogram normal? ❑ Yes ❑ No

Date of last colonoscopy: _____ Was that colonoscopy normal? ❑ Yes ❑ No

Social History

Do you currently smoke? ❑ Yes ❑ No If no, previously? ❑ Yes ❑ No

Years smoked:_____ Packs per day: _____ Do you use other tobacco products? ❑ Yes ❑ No

Consume Alcohol? ❑ Yes ❑ No If yes, drinks per week: _____

Do you do any drugs (including marijuana)? ❑ Yes ❑ No If yes, what drug and for how long? _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you suffer from domestic violence? ❑ Yes ❑ No Do you feel safe at home? ❑ Yes ❑ No

Patient Name: _____ **DOB:** _____

Medical History Have you EVER had any of the following:

❑ Asthma
❑ Psychiatric Disorder/Illness
❑ Cancer
❑ Seizures or Epilepsy
❑ Diabetes
❑ Urinary/Kidney Disorder
❑ Neurological Disorder/Chronic Headaches
❑ Blood Pressure Disorder/Hypertension
❑ Stroke
❑ COPD
❑ Thyroid Disorder
❑ Heart Attack/Heart Disease/Atrial Fib
❑ Arthritis
❑ Pulmonary Embolism/DVT/Blood Clots
❑ Cholesterol Disorder/Hyperlipidemia
❑ Sleep Apnea
❑ Eye Disorder (i.e. Glaucoma)
❑ Other

Please list any other medical illnesses or problems and provide details for any of the above conditions:

_____

_____

Surgery History Please list ANY surgeries you have had and the approximate date.

Procedure	Date	Complications

Prior Cancer Treatment Do you currently have cancer? ❑ Yes ❑ No

Type of Cancer	Year Diagnosed	Treatment	Hospital/Doctor's Office Where You Received Treatment
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:
		❑ Surgery ❑ Biotherapy ❑ Radiation ❑ Radiation Implants ❑ Chemotherapy	Name: Address: Phone:

Obstetrics History

Are you currently pregnant? ❑ Yes ❑ No If yes, anticipated due date: _____

Attempting to conceive? ❑ Yes ❑ No # of Pregnancies:_____ # of Births:_____ # of Miscarriages: _____

Patient Name: _____ **DOB:** _____

Family Medical History Please indicate any major conditions, including cancers, that your immediate family members have had.

Relative	Condition and Description	Living?	If deceased, at what age?
Mother		Y N	
Father		Y N	
Sibling		Y N	
Sibling		Y N	
Sibling		Y N	
Grandparent		Y N	
Grandparent		Y N	
Other		Y N	

Medication List

Medication Name	Dose	Frequency

Do you have additional medications not listed above? ❑ Yes ❑ No If yes, please use the back of this page to list all others.

Allergies

Are you allergic to any medications or other substances? ❑ Yes ❑ No Please list allergies and reactions:

Drug Name	Reaction

Vaccines (immunizations)

Vaccine Name	Date(s)	N/A
COVID-19		
Pneumonia		
Flu		
Shingles		

Patient Name: _____ **DOB:** _____

Review of Systems Please indicate ALL that you have experienced within the last 6-12 months.

General

❑ None ❑ Feeling Tired ❑ Fever ❑ Weight Gain
❑ Chills ❑ Weight Loss ❑ Feeling Poorly

Eyes

❑ None ❑ Dry Eyes ❑ Eye Pain ❑ Itchy Eyes
❑ Vision Changes ❑ Eyesight Problems

Ear/Nose/Throat

❑ None ❑ Earache ❑ Loss of Hearing ❑ Nose Bleeds
❑ Sinus Problems ❑ Sore Throat ❑ Hoarseness

Heart

❑ None ❑ Chest Pain ❑ Palpitations ❑ Slow Heart Rate
❑ Leg Swelling ❑ Fast heart rate ❑ Leg pain, discomfort or fatigue during walking

Lungs/Breathing

❑ None ❑ Cough ❑ Wheezing ❑ Shortness of Breath
❑ Trouble breathing with exertion ❑ Trouble breathing when lying flat

Gastrointestinal

❑ None ❑ Abdominal Pain ❑ Constipation ❑ Diarrhea
❑ Heartburn ❑ Nausea ❑ Vomiting ❑ Blood in stool

Skin

❑ None ❑ Acne ❑ Itching ❑ Change in mole
❑ Skin Lesions ❑ Skin Wound ❑ Breast Lump

Neurological

❑ None ❑ Limb Weakness ❑ Confused ❑ Loss of Memory
❑ Convulsions ❑ Headaches ❑ Dizziness ❑ Difficulty Walking

Psychiatric

❑ None ❑ Suicidal ❑ Anxiety ❑ Disturbed Sleep
❑ Depression ❑ Emotional Problems ❑ Change in Personality

Endocrine

❑ None ❑ Hair Loss ❑ Weak Muscles ❑ Hot Flashes
❑ Feeling Weak ❑ Deepening Voice

Hem/Lymph

❑ None ❑ Easy Bleeding ❑ Easy Bruising ❑ Swollen Glands

Patient Name: _____ **DOB:**_____

CONSENT TO DISCLOSE MEDICAL INFORMATION

Please check one of the following:

_____ **I give permission to the employees of Oncology Hematology Associates (OHA), a division of American Oncology Partners, P.A. (AOP), to disclose my Protected Health Information to me and the following individual(s):**

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

Name: _____ Relation: _____ Phone:_____

_____ I request that all my Protected Health Information be disclosed ONLY to me and no other **individual(s)**.

I understand that I may revoke or change this Consent at any time by filling out another Consent form to replace this one.

_____ _____
Patient Name (Print) Date

_____
Patient or Guarantor (Signature)