

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

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Complete Health Record | <input type="checkbox"/> Medication List   | <input type="checkbox"/> Radiology Results  | <input type="checkbox"/> Complete Billing Record |
| <input type="checkbox"/> New Patient Evaluation | <input type="checkbox"/> Chemo Flow Sheets | <input type="checkbox"/> Radiology CD/Films | <input type="checkbox"/> Other (specify) _____   |
| <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Lab Results       | <input type="checkbox"/> Pathology Slides   | _____  |
| <input type="checkbox"/> Hospital Records       | <input type="checkbox"/> Pathology Results | <input type="checkbox"/> 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 authorize 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 authorization 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 (AOP), to use and disclose the protected health information specified above.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authority to Sign if not patient: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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## 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 (check all that apply):  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:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Asthma                       | <input type="checkbox"/> Neurological Disorder/Chronic Headaches | <input type="checkbox"/> Arthritis                           |
| <input type="checkbox"/> Psychiatric Disorder/Illness | <input type="checkbox"/> Blood Pressure Disorder/Hypertension    | <input type="checkbox"/> Pulmonary Embolism/DVT/Blood Clots  |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Stroke                                  | <input type="checkbox"/> Cholesterol Disorder/Hyperlipidemia |
| <input type="checkbox"/> Seizures or Epilepsy         | <input type="checkbox"/> COPD                                    | <input type="checkbox"/> Sleep Apnea                         |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Thyroid Disorder                        | <input type="checkbox"/> Eye Disorder (i.e. Glaucoma)        |
| <input type="checkbox"/> Urinary/Kidney Disorder      | <input type="checkbox"/> Heart Attack/Heart Disease/Atrial Fib   | <input type="checkbox"/> 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
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> Chemotherapy	Name: Address: Phone:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Biotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Radiation Implants <input type="checkbox"/> 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**

- |                                 |  |   |                                      |
|---------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> None   | <input type="checkbox"/> Feeling Tired | <input type="checkbox"/> Fever          | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight Loss   | <input type="checkbox"/> Feeling Poorly |                                      |

**Eyes**

- |   |  |                                   |                                     |
|---|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Dry Eyes          | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Itchy Eyes |
| <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Eyesight Problems |                                   |                                     |

**Ear/Nose/Throat**

- |   |                                      |  |                                      |
|---|--------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> None           | <input type="checkbox"/> Earache     | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Hoarseness      |                                      |

**Heart**

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> None         | <input type="checkbox"/> Chest Pain      | <input type="checkbox"/> Palpitations                                   | <input type="checkbox"/> Slow Heart Rate |
| <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Fast heart rate | <input type="checkbox"/> Leg pain, discomfort or fatigue during walking |  |

**Lungs/Breathing**

- |  |                                |  |  |
|--|--------------------------------|--|--|
| <input type="checkbox"/> None                            | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing                          | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Trouble breathing with exertion |                                | <input type="checkbox"/> Trouble breathing when lying flat |  |

**Gastrointestinal**

- |                                    |   |                                       |   |
|------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> None      | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea       |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nausea         | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Blood in stool |

**Skin**

- |                                       |                                     |                                      |   |
|---------------------------------------|-------------------------------------|--------------------------------------|---|
| <input type="checkbox"/> None         | <input type="checkbox"/> Acne       | <input type="checkbox"/> Itching     | <input type="checkbox"/> Change in mole |
| <input type="checkbox"/> Skin Lesions | <input type="checkbox"/> Skin Wound | <input type="checkbox"/> Breast Lump |   |

**Neurological**

- |                                      |  |                                    |   |
|--------------------------------------|--|------------------------------------|---|
| <input type="checkbox"/> None        | <input type="checkbox"/> Limb Weakness | <input type="checkbox"/> Confused  | <input type="checkbox"/> Loss of Memory     |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headaches     | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty Walking |

**Psychiatric**

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> None       | <input type="checkbox"/> Suicidal           | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Disturbed Sleep |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Change in Personality |  |

**Endocrine**

- |                                       |  |                                       |                                      |
|---------------------------------------|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None         | <input type="checkbox"/> Hair Loss       | <input type="checkbox"/> Weak Muscles | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Feeling Weak | <input type="checkbox"/> Deepening Voice |                                       |                                      |

**Hem/Lymph**

- |                               |  |  |   |
|-------------------------------|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Swollen Glands |
|-------------------------------|--|--|---|

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**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 (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)