



GYNECOLOGIC CANCER INSTITUTE
of CHICAGO

Welcome to
Gynecologic Cancer Institute of Chicago, LLC.

6700 W 95th Street, Suite 330
Oak Lawn, IL 60453

3825 Highland Avenue, Tower 2, Suite 301
Downers Grove, IL 60515

708-422-3242 phone/ 708-422-3243 fax

www.gcichicago.com

We are the premier gynecologic oncology practice in the Chicago suburbs. Our group was created to provide all-inclusive and accessible gynecologic oncology care and to serve as a center of excellence in gynecologic oncology for patients desiring treatment in the Chicago suburbs. We strive to provide outstanding medical expertise, state of the art treatment, and compassionate care.

At your first visit, you'll meet your doctor and their team (PA-C, resident, medical assistant). Our resident physicians are affiliated with the University of Illinois at Chicago and Midwestern University. The team will review your entire medical history and the details of your current condition. A complete physical exam, including pelvic exam, will be performed during your appointment. Then, your doctor will explain the recommendations for treatment and answer any questions you may have about your medical condition or diagnosis. Sometimes, we'll order additional testing, like CT scans or ultrasounds, to gather more information. When surgery is the best treatment, our surgical coordinator will meet with you to schedule a date and review surgical expectations.

If you need an interpreter please call us 3 days in advance so we can arrange for services. We do have Spanish (Oak Lawn & Downers Grove) and Polish (Oak Lawn) speaking staff. If you wish to bring a family member or other guest with you, we are more than happy to allow them to be with you. Please be mindful that our space is limited. Please limit your guests to no more than 2. Due to the size of your care team, there is usually only space for 1 guest to be in the exam room with you (if you want them present).

Please review the information in this packet prior to your appointment. We have included important details about our financial and privacy policies along with a detailed history form so that we can provide the best possible care for you.

It is our privilege to participate in caring for your health. We look forward to meeting you.



GYNECOLOGIC CANCER INSTITUTE
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FINANCIAL POLICY

We strive to offer the highest quality of care to all patients. Your treatment will not be contingent upon your insurance coverage. Considerable care has been taken in determining our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

INSURANCE: Insurance companies vary greatly in their coverage for medical services. Please be aware that the cost of non-covered services is your responsibility. We will bill your insurance for each service according to the most current billing regulations. We recommend that you personally contact your insurance company with specific questions or concerns regarding your policy. The office will inform you whether or not we are contracted with your insurance, but you are responsible for knowing if your specific plan is in-network or out-of-network.

REFERRALS: Many insurance companies require a referral for a visit to a specialist. Our physicians are specialists in gynecologic oncology so your visit(s) are NOT considered a well woman check, nor a routine OB-GYN visit. Please refer to the front of your insurance card or call your insurance company to understand your coverage and whether you need a referral. ***It is the patient's responsibility to obtain a referral from the primary care physician or gynecologist prior to an appointment.*** Referrals are generally limited to a certain period of time or number of visits, so please ensure your referral is up to date before each visit. Referrals can be mailed or faxed to our office or presented at the time of your visit.

PAYMENT: We expect payment of your co-payment and deductible (when applicable) at the time of service. For your convenience, we are pleased to accept cash, checks, Visa and MasterCard credit cards. Any patient with a balance on their account is required to make a payment prior to the next office visit. The practice mails statements every month with any balance on the account. We will be forced to send a balance to a collection service when no attempt at balance payments have been received. Call our billing coordinator with any questions at 708-422-3242, extension 225.

NON-COVERED SERVICES: As part of your care, your physician may recommend a test or service that is not covered by your insurance plan. Some services that may not be covered by your insurance are: blood tests; bone density test; mammogram; CA-125 blood test, OVA-1 blood test, Pap smear, ultrasound, CT, MRI, or PET scan.

SURGICAL ASSISTANTS: We feel strongly about providing the best quality surgical care. Gynecologic oncology surgeries require tremendous expertise and time, so our physicians often rely on an experienced surgical assistant. This may include a physician's assistant, resident, or certified surgical assistant provided through the hospital. Some insurance companies do not cover non-physician surgical assistants in which case the patient would be responsible for this fee along with any deductible, co-insurance or co-payment.



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ROBOTIC SURGERY: When lifestyle changes, medicine or other treatments do not ease your symptoms, your doctor may suggest surgery. Surgery can include:

- Open surgery: done through one large incision
- Laparoscopic / robotic-assisted *da Vinci* Surgery: this type of minimally invasive surgery is done through a few small incisions

With robotic-assistance, laparoscopic surgeons obtain technical advantages that include visual enhancements, dexterity and ergonomics. The majority of leading payers, such as a Medicare, CIGNA, United Healthcare and most Blue Cross and Blue Shield plans, consider robotic-assistance incidental to the primary surgical procedure and is payable at the carrier’s discretion. The patient is responsible for any charges incurred by this procedure that is not covered by the insurance. The patient may choose to appeal any denials, which is managed by the patient and not the office.

DISABILITY FORMS: Patients who require surgery or chemotherapy often request that we complete forms certifying their disability so they may receive income during treatment. This includes paperwork from your employer such as the Family and Medical Leave Act (FMLA.) Given the volume of these forms and the significant time required from our clinical staff to complete these forms, there is a \$25 fee for completion of initial disability forms. Subsequent disability forms will be priced at \$5 for completion. We require payment of these fees at the time of request. We make every effort to complete disability forms within 7-14 business days of receiving them. In some cases, forms require additional information (pathology or hospital reports) that are not immediately available which may delay their completion.

MISSED or LATE CANCELLED APPOINTMENTS: A GCIC staff member will contact you with a reminder call 1-2 days prior to your appointment. We require at least 48 hours’ notice to cancel an appointment. This allows other patients with an urgent problem the opportunity to be scheduled into that time slot. **Appointments missed or cancelled without the appropriate notice may be subject to a fee of \$25.00.** *Insurance will not cover this charge.*

Late arrival to your appointment will result in that appointment being rescheduled to another day or time at the doctor’s discretion. GCIC will consult with your referring or primary care physician if continued tardiness or absences are recorded.

<u>Service</u>	<u>Fee</u>
FMLA/Disability (initial)	\$25.00
FMLA/Disability (subsequent)	\$5.00
Missed or late cancellation appointment	\$25.00

Prices are subject to change without notice.

Your signature on the acknowledgement page later in this packet documents that you have read and understand this form and agree that you are responsible for the payment of all charges incurred regardless of insurance coverage or other plans available.



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PHYSICIAN ASSISTANTS

Gynecologic Cancer Institute of Chicago employs three Certified Physician Assistants (PA-C): Heather Gannon Stringer, Nicole Burrows, and Brooke Pierson. Certified PA-Cs can address your health care needs and be your trusted adviser when it comes to maintaining or improving your health. PA-Cs obtain medical histories, examine, diagnose and treat patients, order and interpret diagnostic tests and recommend and implement treatment plans. They can perform minor surgery and assist in major surgery, instruct and counsel patients, order or carry out therapy and prescribe medications. PA-Cs perform these roles within a scope of practice established by the supervising doctor in accordance with state regulations; generally speaking, PA-Cs can perform many tasks delegated by the doctor.

They are licensed and certified health care professionals who practice medicine in *partnership with physicians* and bring a breadth of knowledge and skills to patient care. Before they can practice, PA-Cs who graduate from an accredited program, must pass the Physician Assistant National Certifying Exam (PANCE) administered by the National Commission on Certification of Physician Assistants and get licensed by the state in which they will practice.

During the course of your care, you may have follow up appointments scheduled with the physician assistants. The physician assistants maintain chemotherapy regimens and you will also be scheduled with the PA-Cs for chemotherapy related office visits.

Sources:

<http://www.nccpa.net/public>

<https://www.aapa.org/What-is-a-PA/>

Edited to correspond with Gynecologic Cancer Institute of Chicago, LLC standards and procedures.



GYNECOLOGIC CANCER INSTITUTE of CHICAGO

NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We are allowed by law to charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at 708-422-3242.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*



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Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

Pay for your health services

We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information

see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual is deceased.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice became effective April 1, 2015. Please ask a Patient Service Representative or Privacy Officer for assistance or clarification regarding your privacy at Gynecologic Cancer Institute of Chicago, LLC.

Privacy Officer:

Roger Warner

Chief Operating Officer

rwarners@gcicicago.com

708-422-3242



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MEDICAL HISTORY

Today's Date: _____

Name (Last, First): _____ Birthdate: _____ Age: _____

Referring Physician (Last, First): _____

Primary Care Physician (Last, First): _____

REASON FOR VISIT TODAY: _____

PAST MEDICAL HISTORY: _____

PAST SURGICAL HISTORY (include any complications): _____

Do you consent to blood products if necessary in a surgical procedure? Yes No Comment: _____

FAMILY HISTORY OF ILLNESS (please include any history of cancer & specify what type):

Father: Alive: Yes No Cancer: Yes No Type: _____

Mother: Alive: Yes No Cancer: Yes No Type: _____

Other Family Member: _____

ALLERGIES:

To Medications (list name of medication and what reaction you had to it): _____

To Other Products (i.e., food, latex, etc): _____

MEDICATIONS: (please include non-prescription drugs, aspirin, and/or herbal supplements):

Name & Type of Medication	Dosage and Frequency	Name & Type of Medication	Dosage and Frequency

Have you ever been on a hormone replacement therapy? Yes No If yes, how long? _____

SOCIAL HISTORY:

Alcohol usage: Yes No Type: _____ How much: _____ How often: _____

Tobacco usage: (Please check one): Yes No Past Present Type: Cigarettes Cigars Pipe Chew

Illicit drug usage (which drug and last used when): _____

Occupation/Student Status (briefly describe; if retired, please state your previous occupation): _____

How often do you exercise: _____ Who do you live with: _____

OB/GYN:

Last normal period: _____ # of Pregnancies: _____ # of Births: _____ # of C-Sections: _____ # of Normal Vaginal Deliveries: _____

Oral Contraceptive Rx (and how long): _____ Age of 1st Period: _____ # Days of Cycle: _____ # Lifetime Partners: _____

PREVENTATIVE SCREENING (list the date or month/year of test/procedure):

DEXA Scan: _____ Colonoscopy: _____ Mammogram: _____

Pap Smear: _____ History of abnormal pap smears? Yes No Last abnormal pap smear: _____



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Today's Date: _____

Name (Last, First): _____ Birthdate: _____ Age: _____

REVIEW OF SYSTEMS:

AREA	SYMPTOM (please check all that apply)			Other/Detail (Explain any other symptoms)
CONSTITUTIONAL	<input type="checkbox"/> Recent weight loss <input type="checkbox"/> None	<input type="checkbox"/> Recent weight gain <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue		
EYES	<input type="checkbox"/> Pain <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Loss of vision <input type="checkbox"/> None		
EARS, NOSE, THROAT	<input type="checkbox"/> Pain <input type="checkbox"/> Redness	<input type="checkbox"/> Soreness <input type="checkbox"/> None		
CARDIOVASCULAR	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations	<input type="checkbox"/> Irregular Pulse <input type="checkbox"/> Fluid Retention	<input type="checkbox"/> Swelling of Legs <input type="checkbox"/> None	
RESPIRATORY	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough <input type="checkbox"/> Asthma	<input type="checkbox"/> None	
GASTROINTESTINAL	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Distension	<input type="checkbox"/> Bloody stool <input type="checkbox"/> Heart Burn <input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting <input type="checkbox"/> Acid Reflux <input type="checkbox"/> None	
GU Female (urinary system and/or genitals)	<input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Blood <input type="checkbox"/> Vaginal Pain <input type="checkbox"/> None	<input type="checkbox"/> Incontinence <input type="checkbox"/> Slow stream <input type="checkbox"/> Hesitancy <input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Increased Cramping <input type="checkbox"/> Irregular	
MUSCULO/SKELETAL	<input type="checkbox"/> Pains <input type="checkbox"/> Limitation of Range of Motion	<input type="checkbox"/> Sprains <input type="checkbox"/> None	<input type="checkbox"/> Swelling	
INTEGUMENTARY (skin or breast)	<input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Lumps	<input type="checkbox"/> Ulcers <input type="checkbox"/> Scaling <input type="checkbox"/> Tenderness	<input type="checkbox"/> Redness <input type="checkbox"/> Masses <input type="checkbox"/> None	
NEUROLOGICAL	<input type="checkbox"/> Dizziness <input type="checkbox"/> Light-headedness	<input type="checkbox"/> Headaches <input type="checkbox"/> Numbness	<input type="checkbox"/> Weakness <input type="checkbox"/> None	
PSYCHOLOGICAL	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> None	
ENDOCRINE	<input type="checkbox"/> Diabetes <input type="checkbox"/> Adrenal Disease	<input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> None	<input type="checkbox"/> Hypothyroidism	
HEMA/ LYMPH	<input type="checkbox"/> Recent Bleeding	<input type="checkbox"/> Anemia <input type="checkbox"/> None	<input type="checkbox"/> Recent Bruising	
ALLERGIC/IMMUNOLOGY	<input type="checkbox"/> Running Nose	<input type="checkbox"/> Itching Eyes	<input type="checkbox"/> Swelling of Eyes <input type="checkbox"/> None	



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Name (Last, First): _____ Birthdate: _____ Today's Date: _____

Please list the name(s), city and fax number of physicians who have referred you to us, you are seeing or who you want us to send results to.

Patient Physician List

Specialty	Name (first and last name)	Location (city)	Fax
Primary care (family practice or internist)			
Gynecology			
Hematology/Oncology			
Cardiology (heart doctor)			
Pulmonology (lung doctor)			
Breast Surgeon			
General Surgeon			
Gastroenterology			
Urology			
Nephrology (kidney doctor)			
Radiation Oncology			
Dermatology			
Neurology			
Endocrinology			
Reproductive Medicine (IVF)			
Other			



**GYNECOLOGIC CANCER INSTITUTE
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DEMOGRAPHIC FORM

PATIENT INFORMATION	TODAY'S DATE:
Patient Name: _____ (Last, First)	Birth date: _____ Age: _____ Gender: F/M
Address: _____ Apt/Unit _____	Social Security Number _____
City, State, ZIP: _____	<i>The following questions on race, ethnicity & language are required to be asked by Federal Government Regulations. (optional)</i>
Primary phone: _____ home cell work	Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian
Secondary phone: _____ home cell work	<input type="checkbox"/> American Indian/Alaska Native American Indian
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Asian <input type="checkbox"/> Refuse to answer
<input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partner	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Refuse to answer
Spouse/S.O. Name: _____	Language: _____
Spouse/S.O. Phone: _____ home cell work	

GUARANTOR INFORMATION (Party responsible for payment of personal balance) Same as above

Name: _____ (Last, First)	Relationship: _____
Date of Birth: _____	Phone Number: _____
Address: _____	Apt/Unit: _____
City: _____	State: _____ Zip Code: _____

EMERGENCY CONTACT

Name: _____ (Last, First)	Relationship: _____	Phone Number: _____
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PHARMACY INFORMATION

Name of Pharmacy: _____	Pharmacy Phone Number: _____
Pharmacy Address (Cross street information if address is unknown): _____	

I agree that Gynecologic Cancer Institute of Chicago, LLC may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Gynecologic Cancer Institute of Chicago, LLC. I authorize Gynecologic Cancer Institute of Chicago, LLC to release any information required to process my claim. I will notify this practice if my insurance changes at any time during my patient-physician relationship.

I acknowledge that I have reviewed and understand my financial responsibilities under GCIC's Financial Policy. I agree to be responsible for the payment of all charges incurred regardless of insurance coverage or other plans available to me. I also acknowledge that any unpaid balance for which I am financially responsible may be subject to a 33.33% collection fee in addition to the principal balance owed.

Patient Signature _____ **Date** _____



**GYNECOLOGIC CANCER INSTITUTE
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REQUEST FOR ALTERNATIVE COMMUNICATION METHODS

Name (Last, First): _____ Birthdate: _____

Please check the following statements if you agree:

_____ I approve leaving messages regarding my care and appointments at the following phone numbers:

Home: _____ Work: _____

Cell: _____ Fax: _____

_____ I authorize Gynecologic Cancer Institute of Chicago, LLC to release my medical information to the person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain results/information on my behalf. I authorize the person(s) indicated to pick-up materials pertinent to my medical care. I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Spouse: _____ Relative/Friend (list relationship): _____

_____ You may email me at: _____

By providing your email, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access My Care Plus, our Patient Portal. At any time you can change or discontinue emails. By providing your email, you understand the security and privacy risks of patient communication via email and the sending of patient records via email.

POLICY REGARDING THE RECORDING OF PATIENT-PROVIDER CONVERSATIONS

It is the policy of Gynecologic Cancer Institute of Chicago that all patient-provider conversations are privileged and should not be recorded without the written consent of the provider.

Privacy Notice Acknowledgment

I, the undersigned, acknowledge that I have received, read and understand the Notice of Privacy Practices. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I, the undersigned, hereby give my consent to Gynecologic Cancer Institute of Chicago, LLC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available in the office as well as online at www.GCIChicago.com.

Signature _____ **Date** _____



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AUTHORIZATION TO RELEASE INFORMATION

Name (Last, First): _____ Birthdate: _____ Today's Date: _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution _____ Fax _____
Address _____
City _____ State _____ Zip _____

TO: Person/Institution _____ Fax _____
Address _____
City _____ State _____ Zip _____

Disclosure will include: *(check all that apply)*

- _____ Entire Record
- _____ The medical records concerning the time period of _____.
- _____ Operative/Procedure Notes
- _____ Pap Smear Reports
- _____ Biopsy Reports
- _____ Laboratory Reports
- _____ Progress Notes
- _____ Pathology Reports
- _____ CDs of imaging studies (CT, PET, MRI)
- _____ Imaging study reports (CT, PET, MRI, mammograms, x-rays, etc.)
- _____ History and Physical
- _____ Face (demographic) Sheet

- I understand that I have the right to withdraw this authorization at any time.
- I understand that I do not have to sign this authorization to get treatment
- I understand that the medical records to be released may contain information related to HIV status, AIDS, alcohol or drug use, or mental health services and I hereby authorize release of this information. A written request may be submitted if you do not wish to have records containing this information be released to another physician or entity.
- I understand this authorization for release of information is valid for a period of (1) year and may be withdrawn by me at any time except during an action taken in response thereon.
- REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that Gynecologic Cancer Institute of Chicago, LLC cannot guarantee that the Recipient receiving the requested health information will not disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

Patient's Signature _____ **Date** _____