City of Hope®

Instructions for Returning these Forms

There are three ways to return your completed forms. Please choose the option that is most convenient for you:

1. **Email** the completed forms to:

   intake@coh.org

   City of Hope may send my "protected health information" or "PHI", for example, treatment, results, scheduling and other information, to my personal email, if I so choose. I understand that emailing my PHI to an unsecured email carries certain risks that may result in harm to me, including potential access by or transmission to a third party. I understand that if I elect to send or receive PHI by email, City of Hope is not responsible for any unauthorized access to my health information that occurs during transmission and bears no responsibility for safeguarding the PHI once it is transmitted to me.

OR

2. **Fax** the completed forms to:
   City of Hope
   New Patient Experience
   949-777-6750

OR

3. **Mail** the completed forms to:
   (This option may delay processing.)
   City of Hope
   Attention: New Patient Experience
   2520 Elisha Ave.
   Zion, IL 60099

If you have any questions about the status of your forms, please contact your City of Hope Patient Advocate or the New Patient Experience Department at 949-528-6115.

New Patient Intake Form

Please complete all four (4) pages of this form, as applicable. We use this information to request copies of your medical records from your providers. Prior to your appointment, our care team will review your medical records so they can provide you with a thorough medical evaluation. If a provider is not listed on this form, you may be required to complete an additional release form.

Patient name *(please print first and last name)* **Date of birth**

Former names *(due to marriage, adoption or other reasons)*

Physician who recommended City of Hope *(first and last name)*

Current cancer diagnosis **Date of diagnosis** *(mo/year)*

Previous cancer diagnosis *(if applicable)* **Date of diagnosis** *(mo/year)*

Please list dates and types of any upcoming appointments related to your cancer diagnosis

Please indicate ALL services received related to your cancer. Include contact information for ALL providers of cancer care services.

1. DIAGNOSTIC TESTING

Biopsy: ☐ Yes ☐ No **Related to:** ☐ Current diagnosis ☐ Previous diagnosis

Where was your biopsy performed? *(physician office or surgery center name)* **Date(s)**

City **State**

Imaging: ☐ Yes ☐ No **Related to:** ☐ Current diagnosis ☐ Previous diagnosis

What type of imaging was completed? *(CT scan, PET scan, MRI, etc.)*

Where was your imaging completed? *(hospital or clinic name)* **Date(s) or date range**

City **State** **Phone**

Additional facility name *(if applicable)* **Date(s) or date range**

What type of imaging was completed? *(CT scan, PET scan, MRI, etc.)*

City **State** **Phone**

Patient name *(first and last name)* **Date of birth**

Other Diagnostic Tests (blood, cardiology, pulmonary, etc.)

Tests performed

Facility name **Date(s)**

City **State**

2. CANCER TREATMENT

Surgery: ☐ Yes ☐ No **Related to:** ☐ Current diagnosis ☐ Previous diagnosis

Where was surgery performed? *(hospital or surgery center name)* **Date(s)**

City **State**

Physician *(first and last name)* **Phone**

Radiation: ☐ Yes ☐ No **Related to:** ☐ Current diagnosis ☐ Previous diagnosis

Where was radiation treatment provided? *(hospital or surgery center name)* **Date(s) or date range**

City **State**

Physician *(first and last name)* **Phone**

City **State**

Chemotherapy: ☐ Yes ☐ No **Related to:** ☐ Current diagnosis ☐ Previous diagnosis

Where was chemotherapy treatment provided? *(hospital or clinic name)* **Date(s) or date range**

City **State**

Patient name *(first and last name)* **Date of birth**

3. MEDICAL ONCOLOGIST

☐ Yes ☐ No **Related to:** ☐ Current diagnosis ☐ Previous diagnosis

Medical Oncologist *(first and last name)* **Phone**

City **State**

4. PRIMARY CARE

Date of last visit (mo/yr) _____

Physician *(first and last name)* **Phone**

Address

City **State**

5. HOSPITAL VISITS

Have you visited an emergency room or hospital related to this diagnosis? ☐ Yes ☐ No

Name of hospital

City **State** **Phone**

Reason for visit **Date**

Services/treatments received

Patient name *(first and last name)* **Date of birth**

6. OTHER SPECIALISTS

(Urology, Pulmonology, Cardiology, Gastroenterologist, Orthopedic, Neurology, Pain Management, Ear Nose Throat (ENT), Endocrinology (END))

Date of last visit (mo/yr) _____

Physician *(first and last name)* **Specialty** **Phone**

Address

City **State** **Zip Code**

Physician *(first and last name)* **Specialty** **Phone**

Address

City **State** **Zip Code**

I have reviewed all of the information I have provided in this New Patient Intake Form in its entirety and confirm that, to the best of my knowledge, it is true and accurate.

Signature **Date**

Organized Health Care Arrangement Authorization to Release Information

Patient name *(please print first and last name)* **Date of birth**

1. This authorization is valid for release of information for the dates listed on the request.

- I understand that City of Hope may not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization.
- I understand that the use or disclosure of my health information is voluntary except in accordance with federal or state law and any mandatory reporting requirements.
- I understand that once my health information is disclosed it may be re-disclosed by the recipient and the information may not be protected by federal or state privacy laws or regulations.
- I understand that I have the right to inspect and copy the disclosed information.
- I understand that this authorization will expire twelve (12) months from the date signed on this form. This authorization may be revoked at any time by submitting a request in writing to the Health Information Management department; the revocation will not apply to any information already released.
- I understand that I may request a copy of this authorization form.

2. I request and authorize Provider to release the health information specified below, from treatment dates _____ **to** _____ **to Recipients.** (Check all categories or specific categories, as desired. Please enter the approximate date of onset of symptoms and an end date twelve (12) months in the future so we can collect all current and future records, as needed.)

- ☐ Chemotherapy flowsheet
- ☐ Chemotherapy records
- ☐ Consultation
- ☐ Discharge summary
- ☐ EEG and/or EKG
- ☐ Genomic testing
- ☐ History and physical
- ☐ Laboratory reports
- ☐ Medication summary
- ☐ Naturopathic summary
- ☐ Oncology records
- ☐ Operative reports
- ☐ Pathology reports
- ☐ Pathology slides
- ☐ Radiology images
- ☐ Radiology reports
- ☐ Radiation therapy records and notes
- ☐ Rehabilitation notes
- ☐ Other _____

3. MY HIGHLY CONFIDENTIAL INFORMATION: By checking the box(es) and placing my initials next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information indicated next to my initials, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ ____ HIV/AIDS testing or treatment (includingfact that an HIV test was ordered, performed or reported, regardless if whether the results of such tests were positive or negative)
- ☐ ____ Mental Illness or Developmental Disability Treatment
- ☐ ____ Substance Abuse Treatment (i.e. alcohol or drug)
- ☐ ____ Genetic Testing and Information

If in IL or GA:

- ☐ ____ Infertility/IVF/Artificial Insemination
- ☐ ____ Child Abuse and Neglect
- ☐ ____ Sexual Assault
- ☐ ____ Abuse of an adult with disability

4. TERM: This Authorization shall remain in effect for a maximum of twelve (12) months from the date of signature.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below I hereby, knowingly and voluntarily, authorize City of Hope to use or disclose my health information in the manner described above.

Printed Name of Patient (or Personal Representative)	*Signature of Patient (or Personal Representative)*	*Date*	*Time*

If the patient is a minor or is otherwise unable to sign this Authorization, please indicate the relationship of the Personal Representative to the Patient: ☐ Parent ☐ Guardian ☐ Conservator ☐ Agent ☐ Other, specify: _____

Identity of Personal Representative verified via ☐ Photo ID ☐ Matching Signature ☐ Other, specify: _____