Cancer Treatment Centers of America
part of 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:

   es@ctca-hope.com

   Cancer Treatment Centers of America® (CTCA) 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, CTCA® 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:
   Cancer Treatment Centers of America: 847-342-4028

OR

3. **Mail** the completed forms to:
   (This option may delay processing.)

   Cancer Treatment Centers of America
   Attention: New Patient Experience
   500 E. Remington Road
   Schaumburg, IL 60173

If you have any questions about the status of your forms, please contact your CTCA Patient Advocate or the New Patient Experience Department at 866-520-0099.

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Medical History Form

Please complete all five (5) 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 CTCA *(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**

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

☐ Check this box if you do not authorize us to share treatment information with this provider.

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**

City **State** **Phone**

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

Imaging (continued)

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

City **State** **Phone**

☐ Check this box if **you have visited other facilities for imaging.**

Breast Cancer Patients Only

Please list facilities where mammography scans were completed.

Facility name **Date(s)**

City **State** **Phone**

Additional facility name *(if applicable)* **Date(s)**

City **State** **Phone**

Additional facility name *(if applicable)* **Date(s)**

City **State** **Phone**

☐ Check this box if you have **visited other facilities for mammograms.**

Lung Cancer Patients Only

Please list facilities where chest x-rays and scans were completed.

Facility name **Date(s)**

City **State**

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

City **State**

☐ Check this box if you do not authorize us to share treatment information with this provider.

☐ **Check this box if you have seen seen additional physicians at other facilities for lung scans.**

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

Other Diagnostic Tests (blood, cardiology, etc.)

Tests performed

Facility name **Date(s)**

City **State**

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

City **State**

☐ Check this box if you do not authorize us to share treatment information with this provider.

☐ **Check this box if you have seen seen additional physicians at other facilities for diagnostic tests.**

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)* **Specialty** **Phone**

☐ Check this box if you do not authorize us to share treatment information with this provider.

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)* **Specialty** **Phone**

City **State**

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

Radiation (continued)

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

City **State**

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

City **State**

☐ Check this box if you do not authorize us to share treatment information with this provider.

☐ **Check this box if you have seen additional providers, including radiation oncologists, for radiation treatment.**

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**

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

City **State**

☐ Check this box if you do not authorize us to share treatment information with this provider.

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

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

City **State**

☐ Check this box if you do not authorize us to share treatment information with this provider.

☐ **Check this box if you have seen additional providers, including medical oncologists, for chemotherapy treatment.**

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Medical History Form

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

3. PRIMARY CARE

Date of last visit (mo/yr) _____

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

Address

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

☐ Check this box if you do not authorize us to share treatment information with this provider.

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

4. ADDITIONAL PROVIDER

Date of last visit (mo/yr) _____

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

Address

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

☐ Check this box if you do not authorize us to share treatment information with this provider.
☐ **Check this box if you have visited additional providers within the last 12 months.**

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

Signature **Date**

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Organized Healthcare Arrangement Authorization to Release and Disclose Information

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

1. I authorize the medical provider(s) designated on the patient's medical history form ("Provider") to release and disclose the information specified below to the Cancer Treatment Centers of America® (CTCA) facilities ("Recipients") for treatment and all other purposes permitted by law.

☑ Release information ☑ Obtain information

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.)

- ☐ 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. I understand that my health information may include sensitive categories of information listed below. I request and authorize Provider to release all of the information described below if such information exists unless I specify otherwise, below.

- Abuse of an adult with disability
- Child abuse and neglect
- Genetic testing
- HIV/AIDS testing or treatment (including if an HIV test was ordered, performed or reported regardless of results)
- Infertility / IVF / Artificial Insemination
- Mental illness or developmental disability
- Sexual assault
- Substance abuse or diagnoses

I request that Provider withhold the following categories of information from the Recipients named in Section 1:

_____

Patient initials _____ **Date (month/day/year)** _____

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Organized Healthcare Arrangement Authorization to Release and Disclose Information

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

- I understand that CTCA 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 five years from the date signed on this form. The 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.
- I understand that CTCA may contact my employer to obtain a copy of my Summary Plan Document.

Signature
(Patient, Legal Representative or Other Responsible Party)

Date

Relationship to patient
(if signed by other than patient, provide copy of legal document)

Witness signature
(required only for disclosure of information about mental illness or disability of Illinois patients)

Witness name
(please print first and last name)

Cancer Treatment Centers of America® (CTCA) facilities consist of the following:

CTCA® Atlanta

CTCA Chicago

CTCA Phoenix

Outpatient Care Center, Downtown Chicago

Outpatient Care Center, Gurnee (Illinois)

Outpatient Care Center, Gilbert (Arizona)

Outpatient Care Center, North Phoenix

Outpatient Care Center, Scottsdale