Arizona State Urological Institute

The Center for Comprehensive Urological Care

Patient Name: _____ Date of Birth: _____/_____/_____

Please answer the following to the best of your ability. If you are unable to fill out these forms or need assistance, ask the front desk for additional help.

I authorize the following people to access my medical records and information:

Name (First and Last)	Date of Birth (MM/DD/YYYY)	Relationship
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____

Arizona State Urological Institute (ASUI) and Arizona Oncology (AO) share the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. Please select a security question below to verify the individuals whom are authorized to access and discuss your medical records with our office.

- ☐ Security PIN: _____
- ☐ Security Question: _____
  - Answer: _____
- ☐ Security Password: _____
- ☐ Ok to leave a detail message: No ☐ Yes ☐ _____
  List Number ok to leave message on:

Do you have any children? [ ] Yes [ ] No If yes, how many: _____
Do you currently smoke? [ ] Yes [ ] No If yes, how often: _____
Are you a former smoker? [ ] Yes [ ] No If yes, how many years: _____
Do you chew tobacco? [ ] Yes [ ] No

Do you drink alcohol? [ ] No [ ] socially [ ] 1-2 per day [ ] 3-4 per day [ ] Over 4 per day

Have you ever used illegal drugs? [ ] Yes [ ] No

If yes, list what kind(s): _____

Are you currently sexually active? [ ] Yes [ ] No

Have you ever had a sexually transmitted disease (STD)? [ ] Yes [ ] No

If yes, please list type: _____ Date: _____
Type: _____ Date: _____
Type: _____ Date: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____/_____/_____
Other Name: _____
Address: _____ Social Security Number:
_____ _____-_____-_____
_____
_____ Phone: (_____) _____-_____

I hereby authorize (Physician, hospital, or group): _____
_____
_____

To release information to:

Arizona State Urological Institute (ASUI)
2730 S. Val Vista Drive, Building 13, Suite 177
Gilbert, AZ 85295
Phone: (480) 394 - 0200 | Fax: (480) 394 – 0202

[ ] For the following purposes:
_____

OR

[ ] All Records
Medical records may include confidential information related to HIV, communicable disease, alcohol or drug abuse, and mental health diagnosis and treatment.

[ ] **I DO** authorize the release of this type of information.

[ ] **I DO NOT** authorize the release of this type of information.

I understand that:
• I may revoke this authorization, except to the extent that it has already been acted upon.
• Treatment will not be conditioned on my providing this authorization, unless the provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
• Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
• I may have a signed copy of this authorization for my personal records.

_____ _____

Arizona State Urological Institute

The Center for Comprehensive Urological Care

Patient Signature: Date

Arizona State Urological Institute

The Center for Comprehensive Urological Care

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patients Name: _____ Date of Birth: _____/_____/ _____

Other Name: _____ Phone Number: (_____) _____-_____

Address: _____ Social Security Number:

_____ _____-_____-_____

_____

I hereby authorize, (Physician, Hospital or group):

_____

_____

To release information to:

Arizona State Urological Institute (ASUI)
2730 S. Val Vista Drive, Building 13, Suite 177
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- Once this information is released, it may be re-disclosed by the recipient and may no longer be protected information.
- I may have a signed copy of this authorization for my personal records.

_____ _____

Patients Signature: Date

(Patients: This form allows our office to request medical records on your behalf from other physicians, hospitals, and care providers in order to better coordinate your care. Please fill this form out to the best of your ability.)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Arizona State Urological Institute (ASUI) and Arizona Oncology (AO) share the same commitment to protecting your privacy and ensuring that your health information is used and disclosed properly. This Notice of Privacy Practices identifies all potential uses and disclosures of your health information by our Practice, and outlines your rights with regard to your health information. Please sign this form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Arizona Oncology Associates, P.C.:

_____ _____/_____/_____

Signature of Patient or Personal Representative Date

_____

Printed name of Patient or Personal Representative

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The Center for Comprehensive Urological Care

PATIENT CONTACT LIST

Please provide current information that our office can use to contact individuals on your behalf in case of disconnected number, difficulty with reaching you, or an emergency situation.

Emergency Contact: Indicate any person who should be notified in case you experience a medical emergency while at our office.

EMERGENCY CONTACT

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

Non-Emergent Contact: Indicate persons who we may contact if we are having difficulty reaching you. Note: Unless you authorize the following individuals to access your protected health information (PHI), they may not receive test results or office visit information on your behalf.

NON-EMERGENT CONTACT #1

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

NON-EMERGENT CONTACT #2

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

NON-EMERGENT CONTACT #3

Name:_____ Date of Birth:_____/_____/_____

Relationship:_____

Primary Phone: (_____)_____-_____ Alt. Phone: (_____)_____-_____

_____ _____/_____/_____

Print Patient Name: Date

_____

Signature of patient or patient representative