Thank you for contacting our office to schedule your hematology/oncology appointment. We appreciate the trust you have placed in us, and will make every effort to honor that trust through our commitment to providing excellent patient care.

Because we understand how important your time is, we work very hard to stay on schedule. Having your paperwork completed and arriving 30 minutes prior to your scheduled appointment will help reduce your wait. This initial appointment will take approximately 60 minutes.

Your appointment is scheduled on __________________________ at __________________________.

Please arrive 30 minutes before your scheduled time.

Please fill out the enclosed paperwork and bring your insurance cards, photo ID and any co-payments.

If you are unable to keep your appointment, kindly give our office 24 hours notice.

Thank you for not wearing perfume or cologne to our office.
Office Hours

Monday through Friday
9:00 a.m. - 12:00 noon
and
2:00 p.m. - 5:00 p.m.

(949) 499-4540
HISTORICAL DATA SHEET

Patient Name: ___________________________________________________________________

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle initial</th>
</tr>
</thead>
</table>

Preferred Pharmacy Name, Street and Phone #: _________________________________________

Date of Birth: _________________ Age: _____________ Height: _______ Weight: ________

Reason(s) for visit today: __________________________________________________________
_______________________________________________________________________________

Review of Systems (please circle any symptoms you are currently experiencing):

<table>
<thead>
<tr>
<th>General</th>
<th>Gastrointestinal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Feeling Well</td>
<td>Chronic Diarrhea</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Abdominal Mass</td>
</tr>
<tr>
<td>Night sweats</td>
<td>Abdominal Pain</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Black Tarry Stool</td>
</tr>
<tr>
<td>Bruising</td>
<td>Bloody Stool</td>
</tr>
<tr>
<td>Change in wart/mole</td>
<td>Change in Bowel Habits</td>
</tr>
<tr>
<td>Itching</td>
<td>Constipation</td>
</tr>
<tr>
<td>Rash</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Blurred Vision</td>
<td>Difficulty Swallowing</td>
</tr>
<tr>
<td>Headache</td>
<td>Heartburn</td>
</tr>
<tr>
<td>Double Vision</td>
<td>Nausea</td>
</tr>
<tr>
<td>Visual Loss</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Decreased Hearing</td>
<td>Vomiting Blood</td>
</tr>
<tr>
<td>Watery/itchy eyes</td>
<td></td>
</tr>
<tr>
<td>Vertigo</td>
<td></td>
</tr>
<tr>
<td>Nose Bleed</td>
<td></td>
</tr>
<tr>
<td>Bleeding Gums</td>
<td></td>
</tr>
<tr>
<td>Hoarseness</td>
<td></td>
</tr>
<tr>
<td>Sore Throat</td>
<td></td>
</tr>
<tr>
<td>Voice Changes</td>
<td></td>
</tr>
<tr>
<td>Neck Mass</td>
<td></td>
</tr>
<tr>
<td>Swollen Glands</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>Neurological</td>
</tr>
<tr>
<td>Chronic Cough</td>
<td>Numbness</td>
</tr>
<tr>
<td>Cough</td>
<td>Trouble Walking</td>
</tr>
<tr>
<td>Sputum Production</td>
<td>Decreasing Memory</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Difficulty Speaking</td>
</tr>
<tr>
<td>Bloody Sputum</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Breast Mass ( RT / LT )</td>
<td>In-coordination</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Loss of Consciousness</td>
</tr>
<tr>
<td>Chest Pain</td>
<td>Seizures</td>
</tr>
<tr>
<td>Difficulty Breathing on Exertion</td>
<td>Unusual Sensation</td>
</tr>
<tr>
<td>Painting/Blacking Out</td>
<td>Unsteadiness</td>
</tr>
<tr>
<td>Edema</td>
<td>Weakness</td>
</tr>
<tr>
<td>Difficulty Breathing Lying Down</td>
<td></td>
</tr>
<tr>
<td>Rapid Heart Rate</td>
<td></td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td></td>
</tr>
<tr>
<td>Swelling of Extremities</td>
<td></td>
</tr>
<tr>
<td>Hematology</td>
<td>Psychiatric</td>
</tr>
<tr>
<td>Excessive Bleeding</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Abnormal Bleeding</td>
<td>Depression</td>
</tr>
<tr>
<td>Blood Clots</td>
<td>Fearful</td>
</tr>
<tr>
<td>Easy Bruising</td>
<td></td>
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<tr>
<td>Enlarged Lymph Nodes</td>
<td></td>
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<tr>
<td>Pinpoint Hemorrhages</td>
<td></td>
</tr>
<tr>
<td>Prolonged Bleeding</td>
<td></td>
</tr>
<tr>
<td>Spontaneous Bleeding</td>
<td></td>
</tr>
</tbody>
</table>
(Continue) Review of Systems (please circle any symptoms you are currently experiencing):

**Female** Genitourinary..................OR..................**Male** Genitourinary

- Urinary Complaints
- Absence of Menstruation
- Blood in Urine
- Change in Bladder Habits
- Change in Urinary Stream
- Excessive Menstrual Bleeding
- Excessive Non-Menstrual Bleeding
- Flank Pain
- Frequency
- Incontinence
- Menstrual Irregularities
- Painful Urinating
- Pelvic Pain
- Urgency
- Urinating at Night
- Vaginal Bleeding

Past Medical & Surgical History (please circle all pertinent past medical history items):

- Alcohol abuse
- Bleeding disorder
- Cancer of:
  - Brain
  - Breast
  - Cervical
  - Colon
  - Lung
  - Parathyroid
  - Ovarian
  - Prostate
  - Rectal
  - Skin
  - Stomach
  - Throat
  - Thyroid
  - Other:

- Duodenal ulcer
- Congestive heart failure
- COPD (emphysema, chronic bronchitis)
- Hypothyroidism
- Coronary artery disease
- Cerebrovascular accident (CVA)/stroke
- Depression
- CPAP Mask
- Diabetes Mellitus
- Drug dependence
- Gastric ulcer
- Glaucoma
- Heart attack/myocardial infarction
- Hepatitis: A  B  C
- Hiatal hernia
- HIV/AIDS
- Hypertension
- Lupus
- Mononucleosis
- Nasal allergies
- Myeloma
- Pneumonia
- Psychiatric disorder
- Rheumatic heart disease
- Seizures
- Sexually transmitted disease
- Sudden hearing loss
- Thrombophlebitis
- Deep Vein Thrombosis (DVT)
- Pulmonary Embolism (PE)
- Thyroid disorders:
  - Hashimoto’s thyroiditis
  - Hyperthyroidism
  - Hyperparathyroidism
  - Hypoparathyroidism
  - Parathyroidectomy
  - Subacute thyroiditis
  - Thyroid nodule

Other Conditions (please list):

- ______________________________________
- ______________________________________
- ______________________________________

Injuries:

- Accident: Explain _____________

- ______________________________________
- Closed fracture of nasal bones
- Open fracture of nasal bones
- Fracture: _________________________
- Fracture of face bones
- Head injury: _______________________
- Joint injury: ______________________
Family history (please circle all that apply):

- Cancer (unspecified)
- Breast Cancer
- Cervical Cancer
- Colon Cancer
- Ovarian Cancer
- Thyroid Cancer
- Prostate Cancer
- Stomach Cancer
- Melanoma
- Non-Melanoma Skin Cancer
- Leukemia
- Lymphoma
- Multiple Myeloma
- Alcohol Abuse
- Coagulopathy
- Diabetes
- Major Depression
- Sickle Cell Anemia
- Sickle Cell Disease
- Sickle Cell Trait
- Thalassemia

Social history:

Please Circle Appropriately: Married / Divorced / Widowed / Single

- Spouse’s Name: _________________________________________________________________
- Living Situation (ex: lives alone, or with spouse, or with parent(s), or with roommate, etc.) and Current Household Members: ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________

- Occupation (Past or Present): __________________________________________________

- Culture/Ethnicity: _____________________________________________________________

- Sexuality (gay / lesbian / bisexual or heterosexual): ________________________________

- Do you smoke? YES/NO
- Are you exposed to smoke? YES/NO
- Do you drink alcohol? YES/NO
- Drug use? YES/NO

Travel history (please list any recent countries you visited within past year):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please list ALL MEDICATIONS (BOTH PRESCRIPTION AND OVER THE COUNTER), HERBAL MEDICINES, HOMEOPATHIC MEDICINES, AND VITAMINS:

<table>
<thead>
<tr>
<th>NAME:</th>
<th>DOSAGE:</th>
<th>USAGE:</th>
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</tr>
</tbody>
</table>

Allergies (please list ALL medication, food, and environmental allergies):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Please list ALL PREVIOUS SURGERIES, and approximate year performed:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Hospitalizations (please list dates and reasons for hospitalization):

_______________________________________________________________________________

_______________________________________________________________________________

Immunizations up to date? YES / NO  Flu Vaccine this year? YES / NO

Signature of Patient/Guardian  Printed Name of Patient/Guardian  Date
Please PRINT AND complete ALL sections below.

**PATIENT'S PERSONAL INFORMATION**

NAME: _______________________________________________________________________________________________

last name                                                                              first name                                                      initial

ADDRESS ____________________________________________________________ Apt # __________________________

City ____________________________________________________________________________ State______________________ Zip____________________________

Home phone: (_____) ________________________ Cell phone: (_____) _________________________ ☐ Male ☐ Female

Social Security _______-_______-_________          Email: _________________________________________________________________________________

Date of Birth:______________________  Age:______  Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander

☐ Refused to Report ☐ More than one race

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Preferred Language: ☐ English ☐ Other ____________

Employer: ____________________________________________________________________________ Tel. No._

Employer’s Address: _______________________________________________________________________

Spouse’s Name: __________________________________________________________________________

**PATIENT’S INSURANCE INFORMATION**

SOUTHCOST, SAN CLEMENTE

Name of Insured _________________ D O B _______________ Hospital affiliated with? MISSION, SADDLEBACK

Self ☐ Spouse ☐

PRIMARY insurance company’s name:__________________________ Your relation to insured: Other__________

Insurance billing address: _________________________________________________________________

Primary insurance ID number:__________________________ Group number:________________________

SECONDARY insurance company’s name:__________________________ Your relation to insured: Other__________

Insurance billing address: _________________________________________________________________

Secondary insurance ID number:__________________________ Group number:________________________

**PATIENT'S REFERRAL INFORMATION**

Referred by:______________________________________Tel. No._

Primary Care Physician: ____________________________Tel. No._

**EMERGENCY CONTACT**

Name of contact:______________________________________relationship__________________________

Phone number (home): (_____) _________________________

Assignment of Benefits  *  Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Edward Wagner, M.D., and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges not covered by this assignment. In the event of default, I agree to pay all costs of collection, and reasonable attorney’s fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

DATE ____________________              YOUR SIGNATURE __________________________________________________
Thank you for choosing us as your health care provider. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial/Billing Policy, which we ask you to read and sign prior to any treatment.

**INSURANCE**

Insurance billing is done as part of our care for all of our patients. There are hundreds of health insurance companies available in the United States. Please be aware that some of the services provided may be non-covered services and/or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Your insurance policy is a contract between you and your insurance company. It is your responsibility as the subscriber to know what your health insurance may or may not cover as ultimately you are responsible for your bill. It is your responsibility to inform our office of any changes in your insurance or your insurance coverage.

**CASH PATIENTS (no insurance)**

Payment for all services and materials is expected at the time that service is rendered.

**MISCELLANEOUS BILLING POLICIES**

Co Pays and some balances are due before seeing the doctor.

Laboratory services performed or lab specimens processed may be billed separately to you by the laboratory. It is not the doctor’s responsibility to assure insurance coverage for laboratory fees.

Disability and other forms and/or dictated letters are not covered by insurance. There will be a fee of $25.00 for these services billed directly to the patient.

Telephone consultations longer than 15 minutes may be subject to a consultation fee to be charged in accordance to the time spent and the degree of expertise involved.

An APR of 18% is assessed if your account is unpaid after 30 days. Failure to pay your bill may result in the account being given to a collection agency.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

X __________________________________________          Date  ____________________

Patient’s Signature
FINANCIAL/BILLING POLICY

Thank you for choosing us as your health care provider. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial/Billing Policy, which we ask you to read and sign prior to any treatment.

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Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

PATIENT’S COPY
Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Compassionate Oncology Care to release my records and any information to the following individuals.

1. ___________________________Relation to Patient:_________________
2. ___________________________Relation to Patient:_________________
3. ___________________________Relation to Patient:_________________
4. ___________________________Relation to Patient:_________________
5. ___________________________Relation to Patient:_________________

______________________________     __________________
Patient Name (PLEASE PRINT)         Date

Patient Signature
Notice of Privacy Practices Summary

Effective Date: April 14, 2003

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.

This is a summary of your rights and our responsibilities regarding your medical information and its privacy. A full version of this Notice is posted in our office. You may have a copy of the full version by requesting one from the receptionist.

If you have any questions about this notice, please call our Office Manager.

WHO WILL FOLLOW THIS NOTICE?

All health professionals, employees, managers and any related clinics and agencies. (For a listing consult the full version of the Notice.)

OUR PLEDGE REGARDING MEDICAL INFORMATION

We are committed to protecting the privacy of medical information about you.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose your medical information (for examples, consult the full version of the Notice):

- **For Treatment.** To provide you with medical treatment or services.
- **For Payment.** So that you and your insurance carrier may be billed.
- **For Health Care Operations.** For business operations to support your care.
- **Appointment Reminders.** To remind you of appointments.
- **Treatment Alternatives.** To tell you about possible treatment options.
- **Health-Related Benefits and Services.** To tell you about health-related benefits or services.
- **Individuals Involved in Your Care.** To a friend or family member who is involved in your medical care.
- **Disaster Relief.** To those assisting in a disaster relief effort (e.g., the Red Cross).
- **Research.** For research purposes, when approved by our Institutional Review Board.
- **As Required By Law.** When required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** To prevent a serious threat to your health and safety or the health and safety of the public or another person.

SPECIAL SITUATIONS

If any of the following categories describe you, we may use and disclose your medical information as indicated (for examples, consult the full version of the Notice).

- **Organ and Tissue Donation.** If you are an organ or tissue donor, to organizations that handle procurement or transplantation, or to a donation bank.
- **Military and Veterans.** If you are a member of the armed forces or a veteran, as required by military command authorities.
- **Workers’ Compensation.** To your workers’ compensation program, for work-related injuries or illness.
- **Public Health Risks.** For a wide variety of public health activities.
• **Health Oversight Activities.** To a health oversight agency for activities authorized by law (e.g., audits, investigations, inspections, and licensure).

• **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, to a court or lawyer in response to a subpoena, discovery request, or other lawful process.

• **Law Enforcement.** If asked to do so by a law enforcement official, in specific situations.

• **Coroners, Medical Examiners and Funeral Directors.** To a coroner or medical examiner (and/or to funeral directors) as necessary to carry out their duties.

• **National Security and Intelligence Activities.** To authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

• **Protective Services for the President and Others.** To authorized federal officials so they may provide protection to the President and others.

• **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, to the correctional institution or law enforcement official.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the following rights regarding medical information we maintain about you (for details, consult the full version of the Notice):

• **Right to Inspect and Copy.** To inspect and receive a copy of your medical information.

• **Right to Amend.** You may ask us to amend the information you consider incorrect or incomplete.

• **Right to an Accounting of Disclosures.** To request an “accounting of disclosures” (a list of certain disclosures we made of medical information about you).

• **Right to Request Restrictions.** To request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations.

• **Right to Request Confidential Communications.** To request that we communicate with you about medical matters in a certain way or at a certain location.

• **Right to a Paper Copy of This Notice.** To receive a paper copy of this notice.

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We will post a dated copy of the current notice in the facility. (For additional information, consult the full version of the Notice.)

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with this facility or with the Secretary of the Department of Health and Human Services (consult the full version of the Notice). **You will not be penalized for filing a complaint.**

**OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

*Remember: this is a summary of your rights and our responsibilities regarding your medical information and its privacy. A full version of this Notice is posted in our office. You may have a copy of the full version by requesting one from the receptionist. If you have any questions about this notice, please contact our office manager.*
Acknowledgment of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization creates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the health professionals who contribute to my care
- a source of information for applying my diagnosis and clinical information to my bill
- a means by which a third-party payer (eg. insurance carrier) can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and outcomes

I have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

_________________________________________________
Please print patient’s name

_________________________________________________
Witness

Acknowledgment of Receipt of Notice of Privacy Practices was not signed as noted below:

☐ Patient Refused to Sign
☐ Patient was Physically Unable to Sign

The following attempts were made to obtain signature:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Explanation/Reason</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Retain in Patient Record
Authorization to Release Medical Information

| Patient Name: ______________________________ | Date of Birth: ______________ |
| Address: ________________________________ | SS# ________________________ |
| City/State/Zip ____________________________ | Phone: ______________________ |

**CHECK ONE:**
- [ ] Please OBTAIN Information FROM:
- [X] Please SEND my medical information TO:

Edward A. Wagner, M.D. & Associates
Name of Physician, hospital, or other

<table>
<thead>
<tr>
<th>Street Address</th>
<th>Name of Physician, hospital, or other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Edward A. Wagner, M.D. &amp; Associates</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>City/State/Zip</td>
<td></td>
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</tbody>
</table>

**FOR THE PURPOSE OF:**
- [ ] Patient Care
- [ ] Self
- [ ] Insurance Claim
- [ ] Other

List specific dates of records to be released:

**Duration:** This authorization shall begin immediately and remain in effect until: (date) ________________.

**Restrictions:** I understand that the information released may be subject to re-disclosure by the recipient and may no longer be protected. (Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code #56.10(x) may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.)

**Rights:** I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or obtain a copy of any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see page 2 of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

**Signature:**

(Patient/legal representative) ____________________________ Date ______ Time ________

If signed by other than patient, indicate relationship: ________________________________

**Witness:** ______________________________

(Patient/legal representative) ____________________________ Date ______ Time ________