

Arizona Oncology Associates, P.C.

CONTACT LIST			
Patient Name _____		MRN _____	
Contact Name: _____		()	
<i>Last</i>	<i>First</i>	<i>M.I.</i>	<i>Telephone</i>
Address: _____			
<i>City</i>	<i>State</i>		
<input type="checkbox"/> Spouse <input type="checkbox"/> Family (Describe) _____ <input type="checkbox"/> Friend <input type="checkbox"/> Emergency <input type="checkbox"/> Other			
Contact Name: _____		()	
<i>Last</i>	<i>First</i>	<i>M.I.</i>	<i>Telephone</i>
Address: _____			
<i>City</i>	<i>State</i>		
<input type="checkbox"/> Spouse <input type="checkbox"/> Family (Describe) _____ <input type="checkbox"/> Friend <input type="checkbox"/> Emergency <input type="checkbox"/> Other			
Contact Name: _____		()	
<i>Last</i>	<i>First</i>	<i>M.I.</i>	<i>Telephone</i>
Address: _____			
<i>City</i>	<i>State</i>		
<input type="checkbox"/> Spouse <input type="checkbox"/> Family (Describe) _____ <input type="checkbox"/> Friend <input type="checkbox"/> Emergency <input type="checkbox"/> Other			
Contact Name: _____		()	
<i>Last</i>	<i>First</i>	<i>M.I.</i>	<i>Telephone</i>
Address: _____			
<i>City</i>	<i>State</i>		
<input type="checkbox"/> Spouse <input type="checkbox"/> Family (Describe) _____ <input type="checkbox"/> Friend <input type="checkbox"/> Emergency <input type="checkbox"/> Other			

1. I hereby authorize Arizona Oncology Associates, P.C. to use and disclose my personal health information to the individuals identified on this form.
2. I understand that the individuals identified on this form will be treated by Arizona Oncology Associates, P.C. as individuals involved directly in my care and as such Arizona Oncology Associates, P.C. will be allowed to release my personal health information to these individuals for the purposes of treatment, payment and healthcare operations.
3. I understand that I have a right to request and receive a Notice of Privacy Practices from Arizona Oncology Associates, P.C.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original. I voluntarily sign this authorization, and I understand that my ability to obtain health care from Arizona Oncology Associates, P.C. will not be affected if I refuse to sign this authorization.

Patient Signature	Date/Time	AM or PM (circle one)
Personal Representative Signature	Relationship	Date/Time
		AM or PM (circle one)

PHYSICIAN: _____	_____
MRN: _____	LOC: _____
FOR OFFICE USE ONLY	

EMPLOYEE INITIALS