COMPREHENSIVE
CANCER CENTERS

Using and Disclosing Protected Health Information for Involvement in the Individual's Care and Notification Purposes

As per the notice of privacy practices, Comprehensive Cancer Centers must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patients' family member, friends or acquaintances involved in their care.

This document will serve as a written agreement between _____ (patient) and Comprehensive Cancer Centers as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to. It will be the patient's responsibility to update as necessary.

Next of kin:

Name	Phone	Relationship
_____	_____	_____

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes / No Per My Permission – Leave medical information on my answering machine.

I hereby authorize Comprehensive Cancer Centers to use or disclose my personal health information to the above mentioned for the purpose of my care or payment related to my care. This information may also be used for the purpose of notifying, or assist in notification of (including identifying or locating), a family member, personal representative or another person responsible for my care, of my location and/or condition.

_____	_____	_____
Patient Signature	SS #	Date

COMPREHENSIVE
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ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

Comprehensive Cancer Centers of Nevada is committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. 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 the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have <u>received</u> a copy of the Notice of Privacy Practices of Comprehensive Cancer Centers of Nevada.

Date: _____

Name: _____

Signature: _____

Name of Personal Representative *(if appropriate)*: _____

Signature of Personal Representative *(if appropriate):* _____

<u>Comprehensive Cancer Centers of Nevada Use Only</u>

Date acknowledgment received:)_____ -

OR-

Reason acknowledgment was not obtained: _____

_____

_____

_____

COMPREHENSIVE
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Meaningful Use Update

Name: _____

Date of Birth: _____

Race/Ethnicity: _____

Preferred Language: _____

Preferred Method of Contact

Email: _____

Cell: _____

Home: _____

Other: _____

Marital Status

Married	Single	Widowed
Divorced	Life Partner	

COMPREHENSIVE
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User Electronic Mail Authorization Form
Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form**. For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. If you do not have e-mail access, please check the box and sign at the bottom.

_____ _____
Patient Name (First Name, Middle Initial, Last Name) | Date of Birth of Patient

☐ **I do not have e-mail access.** ☐ **I do not want access to the portal.**

Authorized user is:

_____
Authorized User Name (If different from patient)

- ☐ Patient
- ☐ Patient's Guardian (or parent of un-emancipated minor patient)
- ☐ Person authorized to make decisions on behalf of patient (*e.g*. by a medical power of attorney)

_____ _____
Email Address of Patient or Authorized User | Physician's Name

_____ _____
Authorized Signature | Date

_____ _____
Signature of Practice Staff [Confirming user's identity and authority] | Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN_____
Email in PMS_____	iKM Consent_____

COMPREHENSIVE
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Cancer Family History Questionnaire

Please complete this form to the best of your ability and bring it to your next scheduled visit with your physician. This information will assist your physician in knowing the cancers that may run in your biological (blood related) family. When you complete the table below, please include your information as well as information for your parents, sisters, brothers, sons, daughters, grandparents, aunts, uncles, and first cousins. Please sign the form.

Date Form Completed: _____ Date of Birth: _____/_____/_____

Print Name: _____Patient's Signature: _____

Cancer Type	Who was/is affected? At what age was the cancer type found? *For Example: Dad, 45 years old Mom, 67 years old Son, 56 years old*
Ovarian	
Breast	
Uterus	
Colon/rectal	
Prostate	

Are there any other cancers that run in your family?

_____

Are you of Ashkenazi Jewish descent? ☐ **YES** ☐ **NO**

Are you of African American descent? ☐ **YES** ☐ **NO**

Have you or anyone in your blood related family had 20 or more lifetime colon polyps? ☐ **YES** ☐ **NO**

Has anyone in your family had cancer genetic testing? _____If yes, explain: _____

Are you concerned about your personal and/or family history of cancer? _____

For Healthcare Provider/Staff completion:

Recommendations: ☐ Refer for Genetic Counseling *(by MD order or physician standing order).*

☐ No Genetic Counseling referral indicated at this time.

COMPREHENSIVE
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Electronic Prescriptions

Comprehensive Cancer Centers of Nevada uses electronic prescriptions to manager your medications.

By utilizing this system, we can automatically send your prescriptions to your pharmacy. You no longer need to take a paper prescription to your pharmacy for non-narcotic medications.

Certain prescriptions cannot be sent electronically due to federal guidelines. In those cases, your physician will give you a paper prescription to take to your pharmacy.

Refill requests will also be managed in the same manner. Please contact your pharmacy directly to request refills on your medications. They will send an electronic notification to your physician's nurse to obtain approval to refill the medication.

In order to effectively send your prescriptions to the correct pharmacy, we need to collect the following information:

Patient Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Or Cross Streets: _____

Pharmacy Phone Number: _____

Thank you and please let us know if you have any questions.