Dear Patient,

Thank you for choosing Providence Regional Cancer System – RadiantCare Radiation Oncology as your health care provider. We are committed to providing you with excellent customer service.

RadiantCare Radiation Oncology and Providence Health & Services have recently collaborated into one entity now called Providence Regional Cancer System – RadiantCare Radiation Oncology. Along with strengthening an already robust service line and creating new opportunities for efficiency and service, patients will also notice a change in the billing practices.

You will receive two different bills from:

1) Providence Centralia Hospital – for the technical portion of your services
2) RadiantCare Physicians – for the professional portion of your services

Five physicians continue to serve and provide professional medical services for oncology patients and will supervise and direct the radiation treatment services at our treatment facilities. They provide these services under the auspices of an independent-professional limited liability corporation. The physician group (RadiantCare Physicians, PLLC) consists of Haleigh Werner, M.D.; Gregory Allen, M.D., Ph.D.; Justin Suszko, M.D.; Christopher Deig, M.D; and Michael Connor, M.D. All physicians are board certified radiation oncologists with more than 50 years of combined clinical experience.

Additionally, Providence owns and operates the equipment utilized to plan and deliver external beam radiation therapy, including four medical linear accelerators.

If you have any questions about your bill, please call:

Providence: 1-866-747-2455
RadiantCare Physicians: 360-493-5771

Thank you.

RadiantCare PHYSICIANS PLLC

# Patient Questionnaire

**NAME**________________________________________ **DOB**__________ **AGE** ____________

**Name of Support Person with you today?** ______________________ **Relation?** ______________

**Current Diagnosis or Cancer:** ______________________________________________________

**Cancer History:** Previous Cancer ☐ Y ☐ N Type/Location____________________________________

**Current/Prior Treatment:**

Chemotherapy ☐ Y ☐ N Radiation ☐ Y ☐ N Hormone Blockers ☐ Y ☐ N

Facility Treatment Received___________________ Body Part (radiation)___________________

**Cardiac device or other implanted device:** ☐ Y ☐ N Type of device_______________________

**Surgical History:** List relevant/major surgical history

Type of Surgery________________ Year_______ Type of Surgery________________ Year_______

Type of Surgery________________ Year_______ Type of Surgery________________ Year_______

**Family Cancer History:** ☐ None

Relation:______________________ Cancer Type______________________ Age at diagnosis_______

Relation:______________________ Cancer Type______________________ Age at diagnosis_______

**Are you in pain?**

☐Yes ☐ No Where is your pain located?______________________________ Pain Rating 0-10 _______

**Do you have allergies to any of the following**: ☐ Iodine ☐ IV dye ☐ Latex ☐Adhesive

**Medication Allergies/Other Allergies:** ☐ None

Allergy__________________Reaction____________ Allergy__________________Reaction____________

Allergy__________________Reaction____________ Allergy__________________Reaction____________

Allergy__________________Reaction____________ Allergy__________________Reaction____________

**Preferred Pharmacy:** ______________________________________________________

**Alcohol/Substance/Tobacco:**

Do you drink alcohol? ☐ Y ☐ N Average drinks/day_____

Cigarette Smoking History? ☐ Y ☐ N Age started________ Avg Packs/Day________Quit Date ________

Smokeless Tobacco? ☐ Y ☐ N Vape? ☐ Y ☐ N

Other substances use history:

☐ Cocaine ☐ Heroin ☐ Marijuana ☐ Meth ☐ Prescription Pain Meds (recreational or unprescribed)

**Social History:**

Do you live alone? ☐ Y ☐ N Does someone make medical decisions for you? ☐ Y ☐ N Name_________

Current Work ☐FT ☐PT ☐Retired ☐On disability ☐On medical leave ☐Unemployed

Primary type of work (current or previous) ___________________________________________

Do you have concerns about transportation for radiation treatments? ☐ Yes ☐ No

RadiantCare PHYSICIANS PLLC

**Please ✓ any of the following that you have or have a history of:**

**GENERAL**

☐Weight loss (____lbs last 3 months)
☐Fatigue ☐ *mild* ☐ *mod* ☐ *extreme*

**EYES/EARS/NOSE/THROAT**

☐Cataracts ☐ *Right* ☐ *Left*
☐Blind ☐ *Right* ☐ *Left*
☐Excess tearing/double vision/blurry
☐Hearing problems
☐Ringing in ears/buzzing in ears
☐Dental problems
Dentist Name__________________
☐Dentures ☐ *Partial* ☐ *Full*
☐Problem chewing/eating/swallowing
☐Voice hoarseness

**CARDIOVASCULAR**

☐Heart rate irregular/fast/skipped beats
☐High blood pressure
☐Heart failure
☐Prior heart attack/bypass surgery/ stent. When__________________
☐Stroke
☐Feet/ankle swelling (unrelated to position)
☐Blood clots
Cardiologist ____________________

**RESPIRATORY**

☐Shortness of breath
☐Cough Do you use cough medicine? ☐ *Yes* ☐ *No*
☐Coughed up blood in last 3 months
☐Asthma/emphysema/COPD
☐Oxygen # liters _______________
☐Sleep Apnea ☐ *CPAP/BiPAP used*

**GENITOURINARY *(if applicable)***

☐Prostatectomy
☐ ↑ PSA Date of last PSA ________
☐Blood in urine
☐Problems urinating

**GYNECOLOGIC *(if applicable)***

☐Age at first menses_____________
☐Number of pregnancies __________
☐Number of live births___________
☐Age at first delivery___________
☐Vaginal bleeding
☐Hysterectomy for________________
☐Ovaries removed
☐Hormone replacement
Type____________________
\# of years_____
☐Birth control
Type____________________
\# of years_______________
When stopped_____________

****ANY POSSIBILITY OF PREGNANCY?**
**☐ Yes ☐ No****

**SKIN/BREAST**

☐Breast problems
Describe ______________________
☐Mammogram Date:____________
☐Sunburn easily
☐Skin cancer in the past.
Location: ________________
☐Bleeding/enlarging skin sores
☐Nipple retraction/discharge
☐Breast lump
☐Skin dimpling
☐Infection
☐Prior biopsy____________________

**GASTROINTESTINAL**

☐Nausea/vomiting
☐Reflux/Heartburn/GERD
☐Jaundice
☐Diarrhea Meds_________________
☐Constipation Meds _____________
☐Pain in abdomen/pelvis
☐Bowel incontinence
☐Colorectal screening in past 9 years? (FOBT, sigmoidoscopy &/or colonoscopy) ☐ *Yes* ☐ *No*
☐Liver disease/hepatitis
☐Diverticulitis
☐GI tract bleeding
☐Hemorrhoids
☐Stomach ulcers
☐Colostomy/ileostomy

**MUSCULOSKELETAL**

☐Arthritis Where? _______________
☐Muscle weakness
Where?_______________________

**MOBILITY**

☐Normal activity
☐Balance problems
☐Limited self-care/requires assistance
☐Wheelchair bound/bedridden
☐Use walker/cane/crutches
☐Difficulty moving any extremity
☐History of falling in the last year?
☐ Yes ☐ No

**NEUROLOGICAL**

☐ ↑ Headache ☐ *Recent* ☐ *Chronic*
☐Paralysis
☐Tingling/numbness
☐Seizures Frequency_____________
☐Dizziness/vertigo
☐Passing out
☐Memory Loss
☐Tremors
☐Depression/anxiety/suicidality
Treatment_____________________

**ENDO/HEME/LYMPH**

☐Anemia/blood clots
☐Easy bleeding/bruising
☐Enlarged lymph nodes
☐Soaking night sweats
☐Fever
☐Lymphedema

**ANYTHING ELSE WE SHOULD KNOW?**

________________________________
________________________________
________________________________
________________________________

**NURSE NOTES**

Height:__________Weight:_________

BP:_____________ HR: ____________

RR: ______Temp:_______O2:_______

## PATIENT REQUEST FOR CONFIDENTIAL COMMUNICATIONS AND RESTRICTIONS ON THE USE AND DISCLOSURE OF PHI

Name of Patient ________________________________________________________________________________

Date of Birth ____________________________ Medical Record # _________________________________

I understand that RadiantCare Physicians, PLLC, may use or disclose my protected health information (“PHI”) for the purposes of treatment, payment and health care operations. RadiantCare Physicians, PLLC, may also disclose information to someone involved in my care, such as a family member or friend.

You may request to receive Confidential Communications of Protected Health Information (“PHI”) by alternative means or at alternative addresses. You may also request restrictions on RadiantCare Physicians, PLLC, use or disclosure of Protected Health Information “(PHI”). For example, you may not want your appointment notices or your bill to go to your home where a family member might see it.

We may not ask you the reason for your request. RadiantCare Physicians may not comply with the request if it is deemed unreasonable. This restriction is for THIS COURSE OF CARE ONLY and will automatically terminate when your course of care (for this diagnosis) is finished.

☐ I have NO restriction requests for any Communication or Use and Disclosure of my PHI.

☐ I wish to release information to the following person(s) below ONLY:

| Name | Relationship |
|---|---|
| | |
| | |
| | |

☐ Do not send any mailing (including my bill) to my mailing address. Use the address below instead:

| Alternative Address: |
|---|
| City, State, Zip: |

☐ Do not call me at my home phone number. Use the phone number below instead:

| Alternative Phone: |
|---|

☐ Make me a “Confidential” patient. I will not receive ANY mail, email, phone calls or messages.

X_______________________________________________ X ________________________________________

Patient or legally authorized individual signature    Date

________________________________________________ ________________________________________

Printed name if signed on behalf of patient    Relationship (parent, personal representative, etc.)

X_______________________________________________ X ________________________________________

RadiantCare Representative signature of Acceptance    Date

# FINANCIAL POLICY

Thank you for choosing RadiantCare Physicians, PLLC as your health care provider. We are committed to your treatment being successful. Please review the following statement of our Financial Policy and sign to acknowledge that you understand and agree to the terms.

**BILLING AND INSURANCE**

We participate with most major insurance companies, and we will submit your claims for services to your insurance plan(s) as a courtesy. Please keep in mind that payment of your account is ultimately your responsibility, and we will look to you for payment if we are unsuccessful in obtaining reimbursement by your insurance(s). It is important that you notify us immediately if you have any insurance changes.

We do participate with Medicare and we will submit your claims for services. Because we accept assignment, Medicare will be paying our office directly. This means Medicare will pay 80% of all allowable charges and you will be responsible to pay the remaining 20% and the annual deductible. Please provide us with any additional insurance plan(s) you have. We may submit to them, which could reduce the amount you are personally responsible for.

You will receive a statement for which payment is due upon receipt. If your statement reflects an “insurance balance” your claim is still pending payment. If your statement reflects a “patient balance”, this is the portion for which you are responsible. We strongly recommend your active involvement in the management of your account. When you receive your statement, compare it with your insurance explanation of benefits (EOB) to ensure that the balance is correct. If you see payment has not been received by your insurance company, you will need to contact them. In this way, we can work together to ensure insurance companies honor their part of the agreement.

I understand that RadiantCare Physicians, PLLC is providing my professional radiation oncology services. I also understand that I will be getting separate bills for the professional and technical medical services that are provided at Providence Regional Cancer System- RadiantCare facilities.

**USUAL AND CUSTOMARY**

Our practice is committed to providing the best treatment to our patients and our fees are based on what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s determination of usual and customary rates.

**ASSIGNMENT OF BENEFITS**

By signing you are agreeing to request that payment of insurance benefits, including Medicare, if you are a Medicare beneficiary, be made on your behalf to RadiantCare Physicians, PLLC for services provided to you by RadiantCare Physicians, PLLC.

You are also authorizing the release of any medical or other information necessary to determine these benefits or the benefits payable for services to RadiantCare Physicians, PLLC, the Health Care Financing Administration, your insurance carrier or other medical entity. A copy of this authorization will be made available to the Health Care Finance Administration, your insurance company or other entity if requested.

**SELF PAY AND PAYMENT PLANS**

We want to have financial policies that are reasonable and do not create undue hardship. If you need assistance, we will be happy to work with you to set up a flexible payment option. To arrange for this service, please speak with our Billing Specialist or contact them by phone at 360-493-5771.

**NON-PAYMENT OF ACCOUNTS**

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency.

**PAYMENT METHODS**

We realize medical expenses are often unexpected and difficult to plan for. We accept DEBIT, CHECK, MONEY ORDER, MASTERCARD, VISA, AMERICAN EXPRESS and DISCOVER. If you are having a problem paying your account, we encourage you to talk with one of our Billing Specialists.

We charge a fee of $25.00 for each returned check.

If you have any questions about this financial policy or the billing process please contact one of our Billing Specialists at 360-493-5771.

**FINANCIAL POLICY - ACKNOWLEDGEMENT**

I have read, understand, and agree to RadiantCare Physician PLLC's Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments, deductibles, collection, court costs, or reasonable attorney fees in the event of payment default, are my responsibility.

X_______________________________________________ X ________________________________________

Patient or legally authorized individual signature — Date

_______________________________________________ ________________________________________

Printed name if signed on behalf of patient — Relationship (parent, personal representative, etc.)

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The following does not apply to patients with health care insurance:

I have no health care insurance and I understand that I am personally responsible for any medical services rendered by RadiantCare Physicians PLLC, as well as any collection, court costs, or reasonable attorney fees accrued in the event of payment default.

X_______________________________________________ X ________________________________________

Patient or legally authorized individual signature — Date

_______________________________________________ ________________________________________

Printed name if signed on behalf of patient — Relationship (parent, personal representative, etc.)

## NOTICE OF PRIVACY PRACTICES

**This Notice describes how medical information about you may be used and disclosed, and how you can get access to this information. This information will include Protected Health Information (PHI), as that term is defined in privacy regulations issued by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Please review it carefully**.

RadiantCare Physicians respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

**Protected Health Information**
Protected health information means individually identifiable health information:

- Transmitted by electronic media;
- Maintained in any medium described in the definition of electronic media; or
- Transmitted or maintained in any other form or medium.

**Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations**

**For Treatment:**

- Information obtained by a nurse, physician, therapist, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing you care. This will help them stay informed about your care.

**For Payment**
Written patient permission is required to use or disclose PHI for payment purposes, including to your health insurance plan. We will have you sign another form Assignment of Benefits or similar form for this purpose. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

**For Health Care Operations:**

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
  - medical quality review by your health plan;
  - accounting, legal, risk management, and insurance services;
  - Audit functions, including fraud and abuse detection and compliance programs.

**Your Health Information Rights**
The health and billing records we create and store are the property of RadiantCare Physicians, PLLC. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. We have a form available for this type of request. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");

RadiantCare PHYSICIANS PLLC

- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. We have a form available for this type of request. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors.
- Ask that your health information be given to you by another means or at another location. We have a form available for this type of request.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance. We have a form available for this type of request.

**Other Disclosures and Uses of Protected Health Information**

**Notification of Family and Others**
Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. This would be limited to your name and general health condition (for example, "critical," "poor," "fair," "good" or similar statements). In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. We have a form available for this type of request. We are not required to grant the request. But we will comply with any request granted.

**We may use and disclose your protected health information without your authorization as follows:**

- To Comply With Workers' Compensation Law – if you make a workers' compensation claim.
- For Public Health and Safety Purposes as Allowed or Required by Law - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    - to public health or legal authorities
    - to protect public health and safety
    - to prevent or control disease, injury, or disability
    - to report vital statistics such as births or deaths.
- To Report Suspected Abuse or Neglect to public authorities.
- To Correctional Institutions if you are in jail or prison, as necessary for your health and the health and safety of others.
- For Law Enforcement Purposes such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- For Health and Safety Oversight Activities. For example, we may share health information with the Department of Health.
- For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- For Work-Related Conditions That Could Affect Employee Health. For example, an employer may ask us to assess health risks on a job site.
- To the Military Authorities of U.S. and Foreign Military Personnel. For example, the law may require us to provide information necessary to a military mission.
- In the Course of Judicial/Administrative Proceedings at your request, or as directed by a subpoena or court order.
- For Specialized Government Functions. For example, we may share information for national security purposes.
- To Coroners, Medical Examiners, Funeral Directors. We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose PHI to funeral directors, as authorized by law, so that they may carry out their jobs.
- Organ and Tissue Donations. If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate, and transplant organs in order to facilitate an organ, eye or tissue donation and transplantation.

- With Medical Researchers—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- To the Food and Drug Administration (FDA) relating to problems with food, supplements, and products, eye or tissue donation and transplantation.
- Incidental Disclosures. We may use or disclose PHI incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.

**Special Authorizations**
Certain federal and state laws that provide special protections for certain kinds of personal health information call for specific authorizations from you to use or disclose information. When your personal health information falls under these special protections, we will contact you to secure the required authorizations to comply with federal and state laws such as:

- Sexually Transmitted Diseases
- Drug and Alcohol Abuse Treatment Records
- Communicable and Certain Other Diseases Confidentiality
- Confidentiality of Alcohol and Drug Abuse Patients

If we need your health information for any other reason that has not been described in this notice, we will ask for your written authorization before using or disclosing any identifiable health information about you. Most important, if you choose to sign an authorization to disclose information, you can revoke that authorization at a later time to stop any future use and disclosure.

**Other Uses and Disclosures of Protected Health Information**
Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

**Our Responsibilities**
We are required to keep your protected health information private; give you this Notice; and follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our office or medical records department to pick one up.

**To Ask for Help, Comment, or Complaints**
If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Officer at: 4525 3rd Ave SE, Suite 100, Lacey, WA 98503 Tel: 360-412-8960 or 866-612-8960 (toll free)

If you believe your privacy rights have been violated, you may discuss your concerns with our Privacy Officer. You may also file a complaint with the U.S. Secretary of Health and Human Services. For more information about HIPAA or to file a complaint: The US Department of Health & Human Services Office of Civil Rights 2201 Sixth Ave, Mail Stop RX-11, Seattle, WA 98121 Tel: 206-615-2290 or 800-368-1019 (Toll Free) or 206-615-2296 (TDD) 206-615-2297 (Fax) www.hhs.gov/ocr/hipaa (email). We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Effective Date: January 1, 2015

## NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

I acknowledge that I have received a copy of RadiantCare Physicians, PLLC's Notice of Privacy Practices, which provides a description of information uses and disclosures. I further acknowledge that my signature indicates my consent for RadiantCare Physicians to use my protected health information for purposes of treatment, payment and health care operations.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that RadiantCare Physicians is not required to agree to the restrictions I request.

RadiantCare Physicians keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

X______________________________________________ X ________________________________________
Patient or legally authorized individual signature Date

______________________________________________ ________________________________________
Printed name if signed on behalf of patient Relationship (parent, personal representative, etc.)

---------------------------------------------------------------------------------------------------------------------------------------

I made a good faith attempt to obtain the patient's/representative's signature acknowledging receipt of this Notice of Privacy Practices, but was unable to obtain a signature due to the following:

☐ Patient refused to sign ☐ Patient not physically present

☐ Patient physically unable to sign ☐ Other: ________________________________________

______________________________________________ ________________________________________
RadiantCare Representative's Signature Date / Time

This form will be retained in your medical record
Last Update 10/2021

## Authorization for Disclosure of Protected Health Information

Patient Name: ____________________________________________ Date of Birth: ____________________

Address: ________________________________________________________________________________

Phone: ___________________________

**RadiantCare Physicians may disclose the following health information:**

☒ All medical records information (clinic notes, radiology reports, MRI reports, operative reports, etc.)
☐ Health care information in my medical record related to the following treatment/condition: ____________
☐ Health care information in my medical record for the date(s): _ ___________________________________
☐ Other (X-rays, billing information), specify date(s): ___________________________________________
☐ Please do not disclose any health care information related to the following condition(s):________________

**RadiantCare Physicians may disclose health care information regarding testing, diagnosis, and treatment for the following:**

☐ HIV (AIDs virus) ☐ Psychiatric disorders/mental health
☐ Sexually transmitted disease ☐ Drug and/or alcohol use

**You may disclosure this health care information to:**

RadiantCare Physicians
4525 3rd Ave SE, Suite 100
Lacey, WA 98503

RadiantCare Physicians
1200 Basich Blvd
Aberdeen, WA 98620

RadiantCare Physicians
2015 Cooks Hill RD, Suite 100
Centralia, WA 98531

**Reasons for this authorization:** ☒ At my request ☐ Other: ______________________________________

**This authorization expires:**
☒ When my course of care (for this diagnosis only) is finished
☐ On date:________________________________________

**My Rights:**

I understand I do not have to sign this authorization in order to get health care benefits or treatment. However, I do have to sign and an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I understand that I may revoke this authorization by completing a revocation form, which is available in my provider's office, or by writing a letter to RadiantCare Physicians. If I revoke my authorization, it would not affect any actions already taken by RadiantCare Physicians, based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I also understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer be available to protect it.

X ___________________________________________ X ________________________________________
Patient or legally authorized individual signature Date

___________________________________________ ________________________________________
Printed name if signed on behalf of patient Relationship (parent, personal representative, etc.)