GYNECOLOGIC CANCER INSTITUTE
of CHICAGO

Welcome to
Gynecologic Cancer Institute of Chicago, LLC.

6700 W 95th Street, Suite 330
Oak Lawn, IL 60453

3825 Highland Avenue, Tower 2, Suite 301
Downers Grove, IL 60515

708-422-3242 phone/ 708-422-3243 fax

www.gcichicago.com

We are the premier gynecologic oncology practice in the Chicago suburbs. Our group was created to provide all-inclusive and accessible gynecologic oncology care and to serve as a center of excellence in gynecologic oncology for patients desiring treatment in the Chicago suburbs. We strive to provide outstanding medical expertise, state of the art treatment, and compassionate care.

At your first visit, you'll meet your doctor and their team (PA-C, resident, medical assistant). Our resident physicians are affiliated with the University of Illinois at Chicago and Midwestern University. The team will review your entire medical history and the details of your current condition. A complete physical exam, including pelvic exam, will be performed during your appointment. Then, your doctor will explain the recommendations for treatment and answer any questions you may have about your medical condition or diagnosis. Sometimes, we'll order additional testing, like CT scans or ultrasounds, to gather more information. When surgery is the best treatment, our surgical coordinator will meet with you to schedule a date and review surgical expectations.

If you need an interpreter please call us 3 days in advance so we can arrange for services. We do have Spanish (Oak Lawn & Downers Grove) and Polish (Oak Lawn) speaking staff. If you wish to bring a family member or other guest with you, we are more than happy to allow them to be with you. Please be mindful that our space is limited. Please limit your guests to no more than 2. Due to the size of your care team, there is usually only space for 1 guest to be in the exam room with you (if you want them present).

Please review the information in this packet prior to your appointment. We have included important details about our financial and privacy policies along with a detailed history form so that we can provide the best possible care for you.

It is our privilege to participate in caring for your health. We look forward to meeting you.

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FINANCIAL POLICY

We strive to offer the highest quality of care to all patients. Your treatment will not be contingent upon your insurance coverage. Considerable care has been taken in determining our fees. We want to assure you that our charges accurately reflect the complexity of care rendered and the skill and expertise required for your care.

INSURANCE: Insurance companies vary greatly in their coverage for medical services. Please be aware that the cost of non-covered services is your responsibility. We will bill your insurance for each service according to the most current billing regulations. We recommend that you personally contact your insurance company with specific questions or concerns regarding your policy. The office will inform you whether or not we are contracted with your insurance, but you are responsible for knowing if your specific plan is in-network or out-of-network.

REFERRALS: Many insurance companies require a referral for a visit to a specialist. Our physicians are specialists in gynecologic oncology so your visit(s) are NOT considered a well woman check, nor a routine OB-GYN visit. Please refer to the front of your insurance card or call your insurance company to understand your coverage and whether you need a referral. ***It is the patient's responsibility to obtain a referral from the primary care physician or gynecologist prior to an appointment***. Referrals are generally limited to a certain period of time or number of visits, so please ensure your referral is up to date before each visit. Referrals can be mailed or faxed to our office or presented at the time of your visit.

PAYMENT: We expect payment of your co-payment and deductible (when applicable) at the time of service. For your convenience, we are pleased to accept cash, checks, Visa and MasterCard credit cards. Any patient with a balance on their account is required to make a payment prior to the next office visit. The practice mails statements every month with any balance on the account. We will be forced to send a balance to a collection service when no attempt at balance payments have been received. Call our billing coordinator with any questions at 708-422-3242, extension 225.

NON-COVERED SERVICES: As part of your care, your physician may recommend a test or service that is not covered by your insurance plan. Some services that may not be covered by your insurance are: blood tests; bone density test; mammogram; CA-125 blood test, OVA-1 blood test, Pap smear, ultrasound, CT, MRI, or PET scan.

SURGICAL ASSISTANTS: We feel strongly about providing the best quality surgical care. Gynecologic oncology surgeries require tremendous expertise and time, so our physicians often rely on an experienced surgical assistant. This may include a physician's assistant, resident, or certified surgical assistant provided through the hospital. Some insurance companies do not cover non-physician surgical assistants in which case the patient would be responsible for this fee along with any deductible, co-insurance or co-payment.

ROBOTIC SURGERY: When lifestyle changes, medicine or other treatments do not ease your symptoms, your doctor may suggest surgery. Surgery can include:

- Open surgery: done through one large incision
- Laparoscopic / robotic-assisted *da Vinci* Surgery: this type of minimally invasive surgery is done through a few small incisions

With robotic-assistance, laparoscopic surgeons obtain technical advantages that include visual enhancements, dexterity and ergonomics. The majority of leading payers, such as a Medicare, CIGNA, United Healthcare and most Blue Cross and Blue Shield plans, consider robotic-assistance incidental to the primary surgical procedure and is payable at the carrier's discretion. The patient is responsible for any charges incurred by this procedure that is not covered by the insurance. The patient may choose to appeal any denials, which is managed by the patient and not the office.

DISABILITY FORMS: Patients who require surgery or chemotherapy often request that we complete forms certifying their disability so they may receive income during treatment. This includes paperwork from your employer such as the Family and Medical Leave Act (FMLA.) Given the volume of these forms and the significant time required from our clinical staff to complete these forms, there is a $25 fee for completion of initial disability forms. Subsequent disability forms will be priced at $5 for completion. We require payment of these fees at the time of request. We make every effort to complete disability forms within 7-14 business days of receiving them. In some cases, forms require additional information (pathology or hospital reports) that are not immediately available which may delay their completion.

MISSED or LATE CANCELLED APPOINTMENTS: A GCIC staff member will contact you with a reminder call 1-2 days prior to your appointment. We require at least 48 hours' notice to cancel an appointment. This allows other patients with an urgent problem the opportunity to be scheduled into that time slot. **Appointments missed or cancelled without the appropriate notice may be subject to a fee of $25.00**. *Insurance will not cover this charge.*

Late arrival to your appointment will result in that appointment being rescheduled to another day or time at the doctor's discretion. GCIC will consult with your referring or primary care physician if continued tardiness or absences are recorded.

Service	Fee
FMLA/Disability (initial)	$25.00
FMLA/Disability (subsequent)	$5.00
Missed or late cancellation appointment	$25.00

Prices are subject to change without notice.

Your signature on the acknowledgement page later in this packet documents that you have read and understand this form and agree that you are responsible for the payment of all charges incurred regardless of insurance coverage or other plans available.

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PHYSICIAN ASSISTANTS

Gynecologic Cancer Institute of Chicago employs three Certified Physician Assistants (PA-C): Heather Gannon Stringer, Nicole Burrows, and Brooke Pierson. Certified PA-Cs can address your health care needs and be your trusted adviser when it comes to maintaining or improving your health. PA-Cs obtain medical histories, examine, diagnose and treat patients, order and interpret diagnostic tests and recommend and implement treatment plans. They can perform minor surgery and assist in major surgery, instruct and counsel patients, order or carry out therapy and prescribe medications. PA-Cs perform these roles within a scope of practice established by the supervising doctor in accordance with state regulations; generally speaking, PA-Cs can perform many tasks delegated by the doctor.

They are licensed and certified health care professionals who practice medicine in *partnership with physicians* and bring a breadth of knowledge and skills to patient care. Before they can practice, PA-Cs who graduate from an accredited program, must pass the Physician Assistant National Certifying Exam (PANCE) administered by the National Commission on Certification of Physician Assistants and get licensed by the state in which they will practice.

During the course of your care, you may have follow up appointments scheduled with the physician assistants. The physician assistants maintain chemotherapy regimens and you will also be scheduled with the PA-Cs for chemotherapy related office visits.

Sources:
http://www.nccpa.net/public
https://www.aapa.org/What-is-a-PA/
Edited to correspond with Gynecologic Cancer Institute of Chicago, LLC standards and procedures.

GYNECOLOGIC CANCER INSTITUTE

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NOTICE OF PRIVACY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES. 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.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We are allowed by law to charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at 708-422-3242.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the following cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you. *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. *Example: We use health information about you to develop better services for you.*

Pay for your health services

We can use and disclose your health information as we pay for your health services. *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration. *Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information
see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual is deceased.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITITES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice became effective April 1, 2015. Please ask a Patient Service Representative or Privacy Officer for assistance or clarification regarding your privacy at Gynecologic Cancer Institute of Chicago, LLC.

Privacy Officer:
Roger Warner
Chief Operating Officer
rwarner@gcichicago.com
708-422-3242

GYNECOLOGIC CANCER INSTITUTE
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MEDICAL HISTORY

Today's Date: _____________

Name (Last, First):____Birthdate:_________________ Age: ___________
Referring Physician (Last, First): ____
Primary Care Physician (Last, First): ____
REASON FOR VISIT TODAY: ____
____
PAST MEDICAL HISTORY: ____
____
PAST SURGICAL HISTORY (include any complications):____
____
____
Do you consent to blood products if necessary in a surgical procedure? ☐ Yes ☐ No Comment: _________________

FAMILY HISTORY OF ILLNESS (please include any history of cancer & specify what type):
Father: Alive: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No Type:____________________________________
Mother: Alive: ☐ Yes ☐ No Cancer: ☐ Yes ☐ No Type:____________________________________
Other Family Member: ____

ALLERGIES:
To Medications (list name of medication and what reaction you had to it):_______________________________________
____
To Other Products (i.e., food, latex, etc):____

MEDICATIONS: (please include non-prescription drugs, aspirin, and/or herbal supplements):

Name & Type of Medication	Dosage and Frequency	Name & Type of Medication	Dosage and Frequency

Have you ever been on a hormone replacement therapy? ☐Yes ☐No If yes, how long? _____________________

SOCIAL HISTORY:
Alcohol usage: ☐Yes ☐ No Type: ___________________ How much: ________________ How often: _______________
Tobacco usage: (Please check one):☐Yes ☐No ☐Past ☐Present Type: ☐Cigarettes ☐Cigars ☐Pipe ☐Chew
Illicit drug usage (which drug and last used when):____
____
Occupation/Student Status (briefly describe; if retired, please state your previous occupation):_______________________
How often do you exercise: ____________________________ Who do you live with: _________________________________

OB/GYN:
Last normal period: ______ # of Pregnancies: ___ # of Births: ___ # of C-Sections: ___ # of Normal Vaginal Deliveries: ___
Oral Contraceptive Rx (and how long): _______________ Age of 1st Period: __ # Days of Cycle: ___ # Lifetime Partners: ___

PREVENTATIVE SCREENING (list the date or month/year of test/procedure):
DEXA Scan: ________________ Colonoscopy: ________________ Mammogram: ________________
Pap Smear: ________________ History of abnormal pap smears? ☐ Yes ☐ No Last abnormal pap smear: __________

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Today's Date: ___________

Name (Last, First):_______________________________________Birthdate:______________ Age: _________

REVIEW OF SYSTEMS:

AREA	SYMPTOM (please check all that apply)			Other/Detail (Explain any other symptoms)
CONSTITUTIONAL	☐ Recent weight loss ☐ None	☐ Recent weight gain ☐ Weakness ☐ Fatigue		
EYES	☐ Pain ☐ Glaucoma	☐ Loss of vision ☐ None		
EARS, NOSE, THROAT	☐ Pain ☐ Redness	☐ Soreness ☐ None		
CARDIOVASCULAR	☐ Chest Pain ☐ Palpitations	☐ Irregular Pulse ☐ Fluid Retention	☐ Swelling of Legs ☐ None	
RESPIRATORY	☐ Shortness of Breath ☐ Wheezing	☐ Cough ☐ Asthma	☐ None	
GASTROINTESTINAL	☐ Diarrhea ☐ Constipation ☐ Distension	☐ Bloody stool ☐ Heart Burn ☐ Nausea	☐ Vomiting ☐ Acid Reflux ☐ None	
GU Female (urinary system and/or genitals)	☐ Frequency ☐ Urgency ☐ Blood ☐ Vaginal Pain ☐ None	☐ Incontinence ☐ Slow stream ☐ Hesitancy ☐ Vaginal Dryness	☐ Increased Cramping ☐ Irregular	
MUSCULO/SKELETAL	☐ Pains ☐ Limitation of Range of Motion	☐ Sprains ☐ None	☐ Swelling	
INTEGUMENTARY (skin or breast)	☐ Rash ☐ Itching ☐ Lumps	☐ Ulcers ☐ Scaling ☐ Tenderness	☐ Redness ☐ Masses ☐ None	
NEUROLOGICAL	☐ Dizziness ☐ Light-headedness	☐ Headaches ☐ Numbness	☐ Weakness ☐ None	
PSYCHOLOGICAL	☐ Depression	☐ Anxiety	☐ None	
ENDOCRINE	☐ Diabetes ☐ Adrenal Disease	☐ Hyperthyroidism ☐ None	☐ Hypothyroidism	
HEMA/ LYMPH	☐ Recent Bleeding	☐ Anemia ☐ None	☐ Recent Bruising	
ALLERGIC/IMMUNOLOGY	☐ Running Nose	☐ Itching Eyes	☐ Swelling of Eyes ☐ None	

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Name (Last, First):___________________________________ Birthdate: ___________Today's Date: _________

Please list the name(s), city and fax number of physicians who have referred you to us, you are seeing or who you want us to send results to.

Patient Physician List

Specialty	**Name (first and last name)**	**Location (city)**	**Fax**
Primary care (family practice or internist)			
Gynecology			
Hematology/Oncology			
Cardiology (heart doctor)			
Pulmonology (lung doctor)			
Breast Surgeon			
General Surgeon			
Gastroenterology			
Urology			
Nephrology (kidney doctor)			
Radiation Oncology			
Dermatology			
Neurology			
Endocrinology			
Reproductive Medicine (IVF)			
Other			

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DEMOGRAPHIC FORM

PATIENT INFORMATION **TODAY'S DATE:**

Patient Name: ________________________________
(Last, First)

Address: _______________________Apt/Unit______

City, State, ZIP: _______________________________

Primary phone: __________________ home cell work

Secondary phone: ________________ home cell work

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐ Separated ☐ Domestic Partner

Spouse/S.O. Name: ____________________________

Spouse/S.O. Phone: _______________ home cell work

Birth date: _____________ Age: _______ Gender: F/M

Social Security Number_________________________

The following questions on race, ethnicity & language are required to be asked by Federal Government Regulations. (optional)

Race: ☐Black/African American ☐ White/Caucasian ☐American Indian/Alaska Native American Indian ☐Asian ☐Refuse to answer

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Refuse to answer

Language: ___________________________________

GUARANTOR INFORMATION (Party responsible for payment of personal balance) **☐Same as above**

Name: _______________________________________
(Last, First)

Date of Birth: _________________________________

Address: ______________________________________

City:____

Relationship: _________________________________

Phone Number: _______________________________

Apt/Unit: ________________

State: _________________ Zip Code: ____________

EMERGENCY CONTACT

Name: _____________________________ Relationship:__________________ Phone Number: ______________
(Last, First)

PHARMACY INFORMATION

Name of Pharmacy:______________________________ Pharmacy Phone Number:_________________________

Pharmacy Address (Cross street information if address is unknown): __________________________________

I agree that Gynecologic Cancer Institute of Chicago, LLC may e-prescribe my prescriptions and may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Gynecologic Cancer Institute of Chicago, LLC. I authorize Gynecologic Cancer Institute of Chicago, LLC to release any information required to process my claim. I will notify this practice if my insurance changes at any time during my patient-physician relationship.

I acknowledge that I have reviewed and understand my financial responsibilities under GCIC's Financial Policy. I agree to be responsible for the payment of all charges incurred regardless of insurance coverage or other plans available to me. I also acknowledge that any unpaid balance for which I am financially responsible may be subject to a 33.33% collection fee in addition to the principal balance owed.

Patient Signature____ **Date** _________________

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REQUEST FOR ALTERNATIVE COMMUNICATION METHODS

Name (Last, First): ____ Birthdate: ____________________

1. I approve leaving voicemail(s) regarding my care, billing, and appointments at the following numbers:

   Home: ___________________________________ Work: ______________________________________

   Cell: _____________________________________ Fax: ______________________________________

2. I approve receiving *e-appointment reminders* via text and/or email. Please circle: Text / Email / None

3. I approve receiving *e-statements* via text and/or email. Please circle: Text / Email / None

4. I authorize Gynecologic Cancer Institute of Chicago, LLC to release my medical information to the person(s) listed below. I understand that the person(s) named on this authorization will be given access to obtain results/information on my behalf. I authorize the person(s) indicated to pick-up materials pertinent to my medical care. I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s): Please list name and relationship ____________________________________

   ____

5. You may email me at: ____
   By providing your email, 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 My Care Plus, our Patient Portal. At any time you can change or discontinue emails. By providing your email, you understand the security and privacy risks of patient communication via email and the sending of patient records via email.

POLICY REGARDING THE RECORDING OF PATIENT-PROVIDER CONVERSATIONS

It is the policy of Gynecologic Cancer Institute of Chicago that all patient-provider conversations are privileged and should not be recorded without the written consent of the provider**.**

Privacy Notice Acknowledgment

I, the undersigned, acknowledge that I have received, read and understand the Notice of Privacy Practices. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I, the undersigned, hereby give my consent to Gynecologic Cancer Institute of Chicago, LLC to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my patient record. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available in the office as well as online at www.GCIChicago.com.

Signature____ **Date**__________________

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AUTHORIZATION TO RELEASE INFORMATION

Name (Last, First):___________________________________ Birthdate: _____ ______Today's Date: _________

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution____ Fax______________________

Address____

City____________________________State___________Zip_________

TO: Person/Institution____ Fax______________________

Address____

City____________________________State___________Zip_________

Disclosure will include: (*check all that apply*)

______ Entire Record
______ The medical records concerning the time period of __________________.
______ Operative/Procedure Notes
______ Pap Smear Reports
______ Biopsy Reports
______ Laboratory Reports
______ Progress Notes
______ Pathology Reports
______ CDs of imaging studies (CT, PET, MRI)
______ Imaging study reports (CT, PET, MRI, mammograms, x-rays, etc.)
______ History and Physical
______ Face (demographic) Sheet

- I understand that I have the right to withdraw this authorization at any time.
- I understand that I do not have to sign this authorization to get treatment
- I understand that the medical records to be released may contain information related to HIV status, AIDS, alcohol or drug use, or mental health services and I hereby authorize release of this information. A written request may be submitted if you do not wish to have records containing this information be released to another physician or entity.
- I understand this authorization for release of information is valid for a period of (1) year and may be withdrawn by me at any time except during an action taken in response thereon.
- REDISCLOSURE**:** Notice is hereby given to the patient or legal representative signing this Authorization that Gynecologic Cancer Institute of Chicago, LLC cannot guarantee that the Recipient receiving the requested health information will not disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

Patient's Signature____ **Date** ____________________