

**KISHWAUKEE CANCER CARE CENTER**  
 9 Health Services Dr. DeKalb, IL 60115 • 815.756.5255

**PERSONAL INFORMATION**

Name \_\_\_\_\_ Sex  Male  Female Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_ SS# \_\_\_\_\_  
 \_\_\_\_\_ Marital Status:  Married  Single  Widowed  
 Patient's Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Employer's Name: \_\_\_\_\_ Spouse's Name \_\_\_\_\_

**PHYSICIANS**

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_  
 Other Physician consulted regarding present illness: \_\_\_\_\_

**CONTACT INFORMATION: I wish to be contacted in the following manner (check all that apply)**

**Home Telephone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_  
 May leave message with detailed information  May leave message with detailed information  
 May leave message with call-back number only  May leave message with call-back number only  
**Work Telephone** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_  
 May leave message with detailed information  May fax information to the above fax number  
 May leave message with call-back number only

**I give my permission to the staff of the Kishwaukee Cancer Care Center to communicate with the following person(s) listed. It is my intent that the Kishwaukee Cancer Center may communicate information regarding my physical status, results of tests done and answer other questions in regards to my health and treatments. They may also contact these person(s) when attempts to reach me directly are unsuccessful. This person(s) may be contacted regarding need to reschedule appointments, emergent concerns regarding testing and/or need for immediate care.**

DATE	NAME	RELATIONSHIP	PHONE	ALTERNATE PHONE

**I do not want any information released to anyone but myself.**

\_\_\_\_\_  
 (PRINT NAME / DOB)

\_\_\_\_\_  
 (DATE)

\_\_\_\_\_  
 (PATIENT/GUARDIAN SIGNATURE)

\_\_\_\_\_  
 (WITNESS SIGNATURE)

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI (Personal Health Information) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.  
 Healthcare entities must keep records of PHI disclosures. Information provided, if completed properly, will constitute an adequate record.

