CARSON-TAHOE RADIATION ONCOLOGY ASSOCIATES
Gary E. Campbell, M.D. Beth L. Hummer, M.D.
Diplomates, American Board of Radiology
Sandra L. Shirley, PA-C

PATIENT AUTHORIZATION FORM

PATIENT NAME:_____
(please print)

It is the policy of Carson Tahoe Radiation Oncology Associates (CTROA) to make confirmation phone calls to patients on the day before their appointment. Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), it is necessary for us to get your authorization on certain items. Please see below and mark accordingly:

My appointment	yes	no
My medical care	yes	no
My patient account	yes	no

Also, if I am not available, I authorize the staff of CTROA to speak with the following individual(s) regarding my care. yes no

NAME OF INDIVIDUAL	RELATIONSHIP TO PATIENT	PHONE NUMBER

I authorize the staff of CTROA to call my work/cell number, if I am otherwise not available. yes no

I also authorize the staff of CTROA to leave a message on my voice mail at my work number. yes no

I understand that it is the policy of CTROA to take a photo of each patient for their patient chart.

_____ _____
Patient or guardian signature Date

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