VENTURA COUNTY
RADIATION
ONCOLOGY
MEDICAL GROUP, INC.

Timothy A. O'Connor, M.D.
Henry Z. Montes, M.D.

RELEASE OF MEDICAL RECORDS & X-RAY

I _____ authorize _____

_____

to release the following medical records to Ventura County Radiation Oncology Medical Group, Inc. Dr. Timothy A. O'Connor and Dr. Henry Z. Montes.

X-Rays: (Please include report!)

PET Scan(s): _____

Bone Scan: _____

MRI Scan: _____

MAMMO: _____

Ultrasound: _____

Other: _____

Medical Record #: _____

Medical Records

H & P: _____

Consult: _____

OP Report: _____

Pathology: _____

Laboratory: _____

Other: _____

Date of Birth: _____ **SS#:** _____

Patient Signature: _____ **Date:** _____

Please fax to:

☐ 805-981-4456- Oxnard Office- Ph # 805-988-2657

☐ 805-987-3977- Camarillo Office- Ph # 805-484-1919

Please mail to:

☐ 1700 North Rose Ave., Suite 120
Oxnard, CA 93030

☐ 5301 Mission Oaks Blvd., Suite A,
Camarillo, CA 93012

☐ By Fed-Ex Account #: _____

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

Ventura County Radiation Oncology Medical Group, Inc.
1700 N. Rose Ave., Suite 120, Oxnard, CA 93030
5301 Mission Oaks Blvd., Suite A, Camarillo, CA 93012
Timothy A. O'Connor, M.D.
(805)-988-2657

As required by the Health Information Portability and Accountability Act of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels. This medical practice will not ask you why you are making your request, and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to the personal health, treatment or payment for treatment of.
This request supercedes any prior request for confidential channel communications I may have made. Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

☐ Mail

I want you to contact me at the following address:

_____
Address

_____
City, State Zip

☐ Phone

I want you to contact me by telephone:

Cell Phone: _____
☐ Do ☐ Do not leave voicemail messages.

Home Phone: _____
☐ Do ☐ Do not leave messages on my answering machine.
☐ Do ☐ Do not leave messages with any other person.

Work Phone: _____
☐ Do ☐ Do not leave voicemail messages.
☐ Do ☐ Do not leave messages with any other person.

I hereby give my permission to Ventura County Radiation Oncology Medical Group Inc. to disclose information related to my medical care to the individual(s) listed below (e.g. parent, sibling, child, friend):

NAME	RELATIONSHIP	PHONE NO
NAME	RELATIONSHIP	PHONE NO
NAME	RELATIONSHIP	PHONE NO
NAME	RELATIONSHIP	PHONE NO

Signed: _____ Date: _____

Print Name: _____ Date of Birth: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient

****

For office use only:
Date Granted: _____
Date Terminated or Modified: _____

Acknowledgement of Receipt of Notice

Ventura County Radiation Oncology Medical Group, Inc.
1700 N. Rose Ave., Suite 120, Oxnard, CA 93030
5301 Mission Oaks Blvd., Suite A, Camarillo, CA 93012
Timothy A. O'Connor, M. D.
805-988-2657

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception area and that the current notice is available on the company's website: www.rocvc.com.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: _____.

Signed: _____ Date: _____
Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient
☐ beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

☐ Signed form received by: _____

☐ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____