



DATE _____

200 N. Park Street
Kalamazoo, MI 49007
Phone 269-382-2500
Fax 269-373-7431
www.wmcc.org

West Michigan Cancer Center

Radiation & Surgical Specialties

NEW PATIENT SELF-REFERRAL FORM

FAX COMPLETED FORM TO 269-373-7431 or

Mail to:

West Michigan Cancer Center

Attn: Medical Records

200 North Park Street

Kalamazoo, MI 49007

Fax: (269) 373- 7431

Incomplete forms may result in delayed scheduling

Requested Service: Gynecologic Oncology Radiation Oncology Surgical Oncology

Physician Request: Any Dr. _____

Appointment Requested: First Available Urgent

PATIENT INFORMATION

A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD ALONG WITH IDENTIFICATION ARE NEEDED TO SCHEDULE THE APPOINTMENT

Patient Name: _____ DOB: _____

Reason for Referral:

Address:

City: _____ State: _____ Zip code: _____

Phone Number: _____ Cell Number: _____

Gender: Male Female

Email: _____

Interpreter Services Needed: YES NO

If yes, language:

Active Durable Power Of Attorney or Legal Guardian: YES NO If yes, name and phone number below

Name: _____ Phone Number: _____

Have You Received Previous Treatment at Another Facility: YES NO If yes, please provide information below

Physician Name: _____ Phone Number: _____ Fax Number: _____ Dates of Treatment: _____



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WMCC # _____
Patient Name: _____

RECORDS REQUEST – OUTSIDE FACILITY ONLY

I authorize:

Physician Name: _____

Address: _____

Facility Name: _____

Facility Address: _____

Phone #: _____ Fax: _____

to release the following healthcare information regarding:

Patient Name: _____ Date of Birth: _____

1. Records relating to visit(s)/service(s) of: _____

2. Information to be released:

- History & Physical
- Operative Report
- Emergency Room Report
- Other: _____
- X-Ray Films and/or Radiology Reports
- Clinical Resume/Discharge Summary
- Consultation(s)
- Laboratory Report(s)
- Entire Record

In order to protect our patients, **specific authorization is required** to release certain information. If any of the following apply, and you wish to have that information released, you must place your initials on the line next to the appropriate letter(s):

- ___ Treatment of emotional illness, including documentation by any psychologist or psychiatrist (**does not** include psychotherapy notes)
- ___ Treatment of alcohol or substance abuse
- ___ Documentation by Social Service personnel
- ___ Results of HIV testing; treatment of HIV infection, AIDS or AIDS-related complex
- ___ Treatment of venereal disease, tuberculosis or communicable disease as specified by the Michigan Department of Public Health

Information is to be released to:

West Michigan Cancer Center
Attn: Medical Records
200 N. Park Street
Kalamazoo, MI 49007-3731
Fax #: 269-373-0123



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WMCC # _____
Patient Name: _____

RECORDS REQUEST – OUTSIDE FACILITY ONLY

Purpose of Disclosure (i.e. individual's request, insurance, continuing care):

This authorization to release healthcare information will expire on _____. This authorization may be revoked at any time by notifying the organization in writing at West Michigan Cancer Center Radiation & Surgical Specialties (WMCC), Privacy Officer, 200 N. Park St., Kalamazoo, MI 49007, but this will not affect disclosures made prior to receipt of the revocation. If no expiration date is specified, this authorization will expire 1 year after its execution.

I understand that this authorization is voluntary and that any treatment I may seek will not be conditioned upon my signing this authorization.

Applicable federal and state laws protect information used or disclosed pursuant to this authorization. Information that is released may be subject to re-disclosure by the recipient and will no longer be protected by these laws.

By signing this Authorization, I acknowledge that I have read it and that I understand it.

SIGNED _____ DATE ___/___/___
(Patient or Authorized Representative)

PRINTED Patient or Authorized Representative Name: _____

Description of Authorized Representative's Authority to Sign _____