

**CONSENT TO RELEASE INFORMATION TO FAMILY MEMBERS AND/OR FRIENDS**

With the increasing awareness of a patient's right to confidentiality, we are asking all of our patients to complete this form. It will give the doctors and staff guidance as to who should be allowed to receive verbal information about your health care.

*Please complete **ONE** of the 3 options listed below:*

1.  **Do not discuss my medical condition with anyone other than my doctors and professionals who are involved in my healthcare.**

*If you chose this option, **STOP HERE** then sign and date at the bottom.*

2.  **No Restrictions** (May discuss with anyone).

*If you chose this option, **STOP HERE** then sign and date at the bottom.*

3.  **I, \_\_\_\_\_, give the physicians and office staff of Sacramento Clinic for Hematology and Medical Oncology permission to discuss my medical condition with the following individuals:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

and/or (Name): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

and/or (Name): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

and/or (Name): \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

**This consent is in force indefinitely unless you fill in an expiration date or you revoke this consent in writing.**

X  
\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Consent Expiration Date (If any)

The following information is necessary to assist the healthcare team in providing you with comprehensive and individualized care.

<b>PATIENT DEMOGRAPHICS</b>	
Name: _____	Date of First Visit: _____
What do you prefer to be called? _____	Date of Birth: _____
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single	
Race: <input type="checkbox"/> White (Caucasian) <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Native Alaskan	
<input type="checkbox"/> Hispanic (country of origin) _____ <input type="checkbox"/> Other _____	
Where were you born? _____ <div style="display: flex; justify-content: space-between; font-size: small;"> <span>(City)</span> <span>(County)</span> <span>(State)</span> </div>	
Born in foreign country: _____	Moved to US (year): _____
Do you speak/read/understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>ADVANCE DIRECTIVES</b>	
Do you have an advance directive (living will or medical-durable power of attorney)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, please bring a copy with you. If not, would you like to speak with someone about an advance directive? <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>PHYSICIAN INFORMATION</b>	
<b>Please list the complete name, address, and phone number of referring physicians whom you would like to have informed of your diagnosis, treatment, and care.</b>	
Name: _____ <input type="checkbox"/> Check if this is your primary care physician	Specialty: _____
Address: _____	Phone: (    ) _____
Name: _____ <input type="checkbox"/> Check if this is your primary care physician	Specialty: _____
Address: _____	Phone: (    ) _____
Name: _____ <input type="checkbox"/> Check if this is your primary care physician	Specialty: _____
Address: _____	Phone: (    ) _____
<b>HEALTH HISTORY</b>	
<b>Please list all major diseases, illnesses or conditions for which you have been treated or hospitalized.</b>	
<b>Disease/Illness/Condition</b>	<b>Date of Diagnosis</b>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**HEALTH HISTORY (cont.)**

**Have you ever been to the the following? (Check all that apply)**

- Agent Orange                       Asbestos                       Benzine                       Coal Dust  
 Pesticides                       Radiation                       Heavy Metals

**Have you been exposed to, or diagnosed with any of the following? (Check all that apply)**

- Hepatitis                       Shingles                       Tuberculosis (TB)  
 Chicken Pox (exposed within the last 8 weeks)                       Other: \_\_\_\_\_

**Do you smoke, or have you in the past?**       No       Yes       Cigarettes       Pipe       Cigars

Amount per day: \_\_\_\_\_ Number of years: \_\_\_\_\_ Quit date: \_\_\_\_\_

**Do you drink alcohol, or have you in the past?**       No       Yes       Beer       Wine       Hard Alcohol

Amount per day: \_\_\_\_\_ Number of years: \_\_\_\_\_ Quit date: \_\_\_\_\_

**Do you use recreational drugs, or have you in the past?**       No       Yes      Type: \_\_\_\_\_

Amount per day: \_\_\_\_\_ Number of years: \_\_\_\_\_ Quit date: \_\_\_\_\_

**CANCER HISTORY**

Type of cancer (body part with cancer)	Year diagnosed	Treatment	Hospital/doctor's office where you received treatment
		<input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Biotherapy	Name: City/State: Phone #:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Biotherapy	Name: City/State: Phone #:
		<input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation <input type="checkbox"/> Biotherapy	Name: City/State: Phone #:

**Are you using any alternative treatments?**       No       Yes

*If yes, please check all that apply:*       Herbal supplement       Nutritional aids       Vitamins  
 Relaxation                       Therapeutic touch       Other: \_\_\_\_\_

**Please list any immediate family members who have had cancer (Mother, Father, Sister, Brother)**

Relative	Type of Cancer	Age when diagnosed	Still Living?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please list any *other* relatives who have had cancer (Grandparents, Aunts, Uncles, Cousins).  
Do not include people who are related to you only by marriage.**

Relative	Related to you through:	Type of Cancer
	<input type="checkbox"/> Mother <input type="checkbox"/> Father	
	<input type="checkbox"/> Mother <input type="checkbox"/> Father	
	<input type="checkbox"/> Mother <input type="checkbox"/> Father	

## SOCIAL DEMOGRAPHICS/FAMILY

With whom do you live? \_\_\_\_\_

Do you have children?  No  Yes Ages: \_\_\_\_\_

Are you responsible for the care of someone else?  No  Yes Whom? \_\_\_\_\_

If you are in need of help at home, who will be available to assist you? \_\_\_\_\_

What is your highest level of education?  Grade school  High school  College  Post-graduate

What is the easiest way for you to learn new things?  Written  Video  
 Demonstration  Oral Instruction

Are you employed?  Yes  Self-employed  
 No Date you stopped working \_\_\_\_\_  Retired  Disabled

What is/was your occupation? \_\_\_\_\_

Are you having employment problems?  No  Yes (please explain): \_\_\_\_\_

Is spirituality/religion important in your life?  No  Yes

Are there any religious, traditional, ethnic, or cultural practices that you would like to be part of your care?

No  Yes (please explain): \_\_\_\_\_

## COPING

Since you became ill, have you felt any of the following? (check all that apply)

- Nervous, or more nervous than normal  Overwhelmed by emotions  Angry  
 Depressed, or more depressed than normal  Difficulty with concentration  Sad  
 Other: \_\_\_\_\_

Do you have a lot of stress in your life?  No  Yes

Have you noticed a change in your normal sleeping pattern?

(sleeping more than usual, or difficulty in sleeping)

If yes, explain: \_\_\_\_\_  No  Yes

Have you ever taken medications for emotional problems?  No  Yes

Have you ever been hospitalized for emotional problems?  No  Yes

Are you concerned about how your illness will affect your family?  No  Yes

Are you concerned about any particular member of your family who may have experienced difficult emotional reactions as a result of your illness?  No  Yes

Since your diagnosis, have you noticed a change in your relationship with your partner?  No  Yes

Do you have concerns about sexual/reproductive issues?  No  Yes

Have you experienced changes in your sexual desire or function that are troubling you?  No  Yes

Have you ever been physically, emotionally, verbally, or sexually abused?  No  Yes  
If you have been abused, have you sought help?  No  Yes

Are you concerned about how your illness will affect your financial resources?  No  Yes

Are you comfortable whether or not your insurance coverage and personal resources can meet the costs of your care?  No  Yes

Are you having problems with the cost of your medications?  No  Yes

What concerns you most about your illness? \_\_\_\_\_

## SKIN

Do you have any of the following? (Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Changes in moles | <input type="checkbox"/> Tendency to bruise easily | <input type="checkbox"/> Mouth sores or mouth ulcers |
| <input type="checkbox"/> Jaundice         | <input type="checkbox"/> Changes in skin color     | <input type="checkbox"/> New sores or open wounds    |
| <input type="checkbox"/> Rashes           | <input type="checkbox"/> Dry or itchy skin         | <input type="checkbox"/> Other: _____                |

## NUTRITION

Have you lost 10 pounds or more in the last 1-3 months without trying?  No  Yes

Have you been eating fewer than 2 meals per day, or have you been skipping regular meals?  No  Yes

Do you become full easily and eat less than you used to?  No  Yes

Are you physically able to shop, cook, and/or eat?  No  Yes

Do you have enough money to buy the food you need?  No  Yes

Please check any of the following symptoms that are preventing you from eating:

- |                                   |  |   |
|-----------------------------------|--|---|
| <input type="checkbox"/> Nausea   | <input type="checkbox"/> Vomiting        | <input type="checkbox"/> Loss of appetite         |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Pain            | <input type="checkbox"/> Mouth or throat problems |
| <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Change in taste | <input type="checkbox"/> Other: _____             |

## ACTIVITY

Are you having difficulty walking?  No  Yes

Have you fallen in the last month?  No  Yes

Have you noticed a difference in your strength/dexterity that interferes with your daily activity?  No  Yes

Do you need help with any of the following:

- |                                  |                                    |   |  |   |
|----------------------------------|------------------------------------|---|--|---|
| <input type="checkbox"/> Eating  | <input type="checkbox"/> Bathing   | <input type="checkbox"/> Dressing       | <input type="checkbox"/> Climbing Stairs   | <input type="checkbox"/> Meal Preparation |
| <input type="checkbox"/> Writing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Transportation | <input type="checkbox"/> Taking Medication |   |

## HOME CARE INFORMATION

If you have home care services or home care infusion services, please list the names and phone numbers of these agencies:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## ACCESS DEVICE

Do you have a catheter in your arm or chest for drawing blood or for receiving medication?  No  Yes

If yes, please complete the following:

What type of catheter do you have? \_\_\_\_\_

When was it inserted? \_\_\_\_\_

Who placed the catheter? \_\_\_\_\_

At what facility was the catheter inserted? \_\_\_\_\_

What is the catheter used for? \_\_\_\_\_

Have you had any problems or difficulties with your catheter?  No  Yes

If yes, please explain: \_\_\_\_\_

## COMFORT

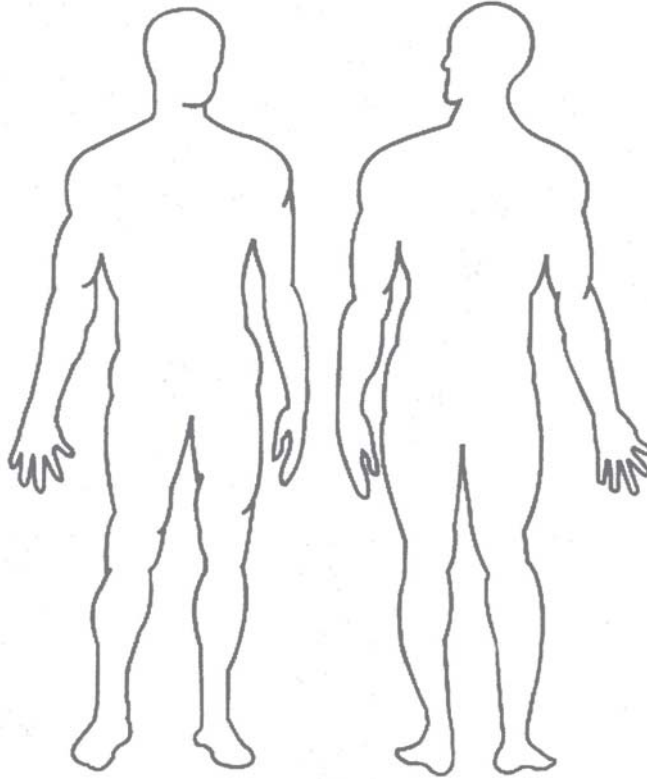
Have you had pain today?  No  Yes

If yes, please describe: \_\_\_\_\_

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On the diagram, mark the areas where you feel pain.



Please rate your pain by circling the number that best describes your pain at its worst in the past 24 hours.

(no pain)    0    1    2    3    4    5    6    7    8    9    10    (worst pain)

During the past 24 hours, has the pain interfered with your:

General activity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Sleep/Rest/Relaxation	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mood	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Walking ability	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Enjoyment of life	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Normal work	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Relations with other people	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

What treatment or medications are you receiving for your pain? \_\_\_\_\_

## ADDITIONAL INFORMATION

Please list any additional information that you think would assist us in providing you the best possible care:

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Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent weight change?  No  Yes

**Head, Eyes, Ears, Nose, Throat & Neck**

Double Vision  No  Yes  
Headaches  No  Yes  
Seizures  No  Yes  
Dizziness  No  Yes  
Hard of hearing  No  Yes  
Thyroid problems  No  Yes  
Other (please explain): \_\_\_\_\_

**Respiratory:**

Spitting up blood  No  Yes  
Asthma/Wheezing  No  Yes  
Difficulty Breathing  No  Yes  
Pleurisy/pneumonia  No  Yes  
Other (please explain): \_\_\_\_\_

**Cardiovascular:**

Chest pain/angina  No  Yes  
Shortness of breath  No  Yes  
Difficulty walking (2 blocks)  No  Yes  
Heart problems/attacks  No  Yes  
High blood pressure  No  Yes  
Heart murmur  No  Yes  
Swelling of hands, feet  No  Yes  
Other (please explain): \_\_\_\_\_

**Hematologic:**

Bleeding tendencies  No  Yes  
Anemia  No  Yes  
Blood disease  No  Yes  
Other (please explain): \_\_\_\_\_

**Gastrointestinal**

Peptic Ulcer  No  Yes  
Vomiting blood/food  No  Yes  
Gallbladder disease  No  Yes  
Liver problems  No  Yes  
Hepatitis  No  Yes  
Painful bowel movements  No  Yes  
Bleeding w/bowel movements  No  Yes  
Black stools  No  Yes  
Hemorrhoids  No  Yes  
Recent change in bowel habits  No  Yes  
Frequent diarrhea  No  Yes  
Heartburn  No  Yes  
Cramping/pain in abdomen  No  Yes  
Food sticking in throat  No  Yes  
Other (please explain): \_\_\_\_\_

**Neuro-Psychiatric:**

Loss of consciousness  No  Yes  
Convulsions  No  Yes  
Fainting spells  No  Yes  
Prior psychiatric history  No  Yes  
Other (please explain): \_\_\_\_\_

**Genitourinary:**

Frequent urination  No  Yes  
Burning/painful urination  No  Yes  
Blood in urine  No  Yes  
Kidney problems  No  Yes  
Other (please explain): \_\_\_\_\_

**WOMEN ONLY:**

Age your periods started: \_\_\_\_\_  
Are you still having regular menstrual periods?  No  Yes  
If no, at what age did your periods stop? \_\_\_\_\_  
If yes, date of your last period: \_\_\_\_\_  
Number of days period lasts: \_\_\_\_\_  
Do you have pain with your periods?  No  Yes  
Number of pregnancies: \_\_\_\_\_  
Number of miscarriages: \_\_\_\_\_  
Number of children: \_\_\_\_\_  
Age at time of your first delivery: \_\_\_\_\_  
Did you nurse your child(ren)?  No  Yes  
Do you practice monthly breast self-examinations?  No  Yes

Date of last PAP smear: \_\_\_\_\_  
Results: \_\_\_\_\_  
Ever been treated for abnormal PAP smear?  No  Yes  
Explain: \_\_\_\_\_  
Ever had a pelvic infection?  No  Yes  
Do you currently use birth control?  No  Yes  
What type: \_\_\_\_\_  
What other birth control have you used in the past?  
\_\_\_\_\_  
Have you had a hysterectomy?  No  Yes  
Are you currently on hormone therapy?  No  Yes

Signature of Patient **X** \_\_\_\_\_ Date: \_\_\_\_\_

**or**  
Signature of person completing this form **X** \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_



**INFORMATION NEEDED FOR CASE HISTORY FILE**

Male  Female

Patient's Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Today's Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ City/State of Birth \_\_\_\_\_

Permanent Address \_\_\_\_\_ Home Phone ( \_\_\_\_\_ )

City, State, ZIP \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ )

Temporary Address \_\_\_\_\_ Phone ( \_\_\_\_\_ )

City, State, ZIP \_\_\_\_\_

**RACE** (The State of California Tumor Registry asks cancer treatment centers to report patient race. You may decline to give this information if you choose.)

White  Black  Hispanic  Native American  Japanese  Korean  Chinese  Filipino

Vietnamese  Hawaiian  Asian Indian, Pakistani  Other: \_\_\_\_\_  Decline to state

Patient's Employer \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Spouse/Next of Kin \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) Work Phone ( \_\_\_\_\_ ) Cell Phone ( \_\_\_\_\_ )

Emergency Contact (not living with you) \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) Work Phone ( \_\_\_\_\_ ) Cell Phone ( \_\_\_\_\_ )

Referring Physician \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Address \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Address \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Address \_\_\_\_\_

**MEDICAL INSURANCE COVERAGE - PLEASE BRING YOUR INSURANCE CARD**

Primary Insurance Company \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_  Male  Female

Secondary Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_  Male  Female

**RESPONSIBLE PARTY FOR PATIENT UNDER 18 YEARS OF AGE**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) Cell Phone ( \_\_\_\_\_ )

Employer \_\_\_\_\_ Employer Phone ( \_\_\_\_\_ )

**STAFF USE ONLY:** ID VERIFICATION: \_\_\_ Photo ID \_\_\_ Other: \_\_\_\_\_ (Initials: \_\_\_\_\_)

I, \_\_\_\_\_  
Print Patient Name

- Authorize my referring physician to release all medical information necessary to complete my medical care.
- Authorize RAS Sacramento Clinic for Hematology and Medical Oncology to request/obtain medical information/x-rays from other healthcare providers for the purpose of diagnosis and/or treatment.
- Authorize RAS Sacramento Clinic for Hematology and Medical Oncology to release any medical information/x-rays requested by other healthcare providers.
- Authorize the release of all medical information necessary to process this claim.
- Authorize payment of medical benefits directly to the physician or supplier of services itemized on said claim.
- Understand that fees are subject to change based on actual exam(s) performed.
- Understand that I am responsible for any charges or charge balances not paid by my insurance and agree to pay these amounts.
- Understand that in the event legal action should become necessary to collect an unpaid balance due for medical services rendered, I agree to pay for reasonable attorney fees or other such costs as the court determines proper.
- I hereby acknowledge the receipt of a copy of the RAS Notice of Privacy Practices.

\_\_\_\_\_  
Initials

\_\_\_\_\_  
Date

**X**  
\_\_\_\_\_  
Patient/Responsible Party Signature

Note: Declining to sign or altering this form will result in RAS being unable to provide service to you.

**AUTHORIZATION TO USE OR RELEASE PROTECTED HEALTH INFORMATION**

I hereby authorize \_\_\_\_\_

To release health information and records obtained during the course of treatment of:

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Patient's Phone # ( \_\_\_\_\_ )

1. The information is to be used or disclosed to the following **person or entity**:

Person/Entity Name \_\_\_\_\_ Phone # ( \_\_\_\_\_ )

Address \_\_\_\_\_

2. Purpose:     At the request of the patient                       Other: \_\_\_\_\_

3. The information to be used or disclosed includes only those items checked below, with respect to services provided on or around (insert date of service): \_\_\_\_\_. If this line is left blank, the treatment dates covered by this authorization are from the most recent office visit.

I understand that this authorization extends to all or any part of the records/information designated below. The information to be used or released includes:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> History and Physical Exam         | <input type="checkbox"/> Demographic Information   |
| <input type="checkbox"/> Pathology          | <input type="checkbox"/> Treatment Plans                   | <input type="checkbox"/> Progress Notes            |
| <input type="checkbox"/> Laboratory Data    | <input type="checkbox"/> Diagnostic Imaging Reports/Films* | <input type="checkbox"/> Consultation Notes        |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Assessments                       | <input type="checkbox"/> Billing/Financial Records |

\*List **ALL** dates and types of exams for films to be released

This authorization is limited to only that information that I have requested above to be used or disclosed to the person/entity named herein.

**FOR THE RECIPIENT OF THE INFORMATION:**

If any of the requested records contain information regarding HIV, alcohol or drug abuse treatment, it is protected by federal confidentiality rules (42 CFR Part 1). The federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**NOTE: CALIFORNIA STATE LAW REQUIRES A SEPARATE AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS, DRUG AND/OR ALCOHOL ABUSE RECORDS AND/OR HIV TEST RESULTS.**

**AUTHORIZATION TO USE OR RELEASE PROTECTED HEALTH INFORMATION**

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Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

1. **Expiration:** I understand that this authorization is in force indefinitely unless I fill in an expiration date or I revoke this authorization in writing.
2. **Re-disclosure:** I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be used or re-disclosed by the receiving party.
3. **Refusal to sign:** I understand that I may refuse to sign this authorization and that Sacramento Clinic for Hematology and Medical Oncology will not condition treatment, payment, or eligibility for benefits on whether I sign this authorization.
4. **Certification:** I certify that I am the patient and the identification that I have provided is true and correct.
5. **Revocation:** I have the right to make a written request to stop the use or release of information at any time, although I understand that I cannot do anything about information already used or disclosed under this authorization. The revocation must include:
  - Patient's name, address and date of birth
  - The patient's desire to revoke this authorization, and
  - The date of the revocation and the patient's signature
6. **Copy:** I understand that I will receive a copy of this authorization.

**I fully understand and accept the terms of this authorization.**

**X** \_\_\_\_\_  
 (Patient Signature) (Date)

Expiration Date (if any) \_\_\_\_\_

**(INTERNAL USE ONLY)**

I have verified the patient's signature against the medical record.

\_\_\_\_\_  
 (Date) (Employee Initials/Title) (Department)

Please mail form with original signature to:

**Sacramento Clinic for Hematology and Medical Oncology**  
 Attn: Medical Records  
 2929 K Street, Suite 200  
 Sacramento, California 95816