

UCSF Carol Franc Buck Breast Care Center

Patient Information

1600 Divisadero Street, 2nd Floor UCSF Comprehensive Cancer Center
San Francisco, California 94115

For **surgery** Tel: (415) 353-7111 or for **oncology** (415) 353-7070 **Fax** (415) 353-3074

Last updated (date) _____

Please fill out the information below as completely as possible. We need to have the full mailing addresses of any other physicians or medical providers involved with your care, so that we may send them updates on any treatment or services you receive at the Breast Care Center.

Your Information:

Name: _____ SS #: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone:(H) () _____ (W) () _____

Referring MD:

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone:() _____ (Fax) () _____

Primary Care Physician:

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone:() _____ (Fax) () _____

Surgeon:

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone:() _____ (Fax) () _____

Medical Oncologist:

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone:() _____ (Fax) () _____

Other:

Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone:() _____ (Fax) () _____



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Tel: (415) 353-7111 surgery or (415) 353-7070 oncology Fax: (415) 353-7021

Consent to Release Information & Financial Waiver

Patient Information:

Name _____ Medical Record # _____

Address: _____ City _____ State _____ Zip _____

Phone (h) () _____ (W) () _____

Referring MD

Primary Care MD

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State _____ Zip _____

City: _____ State _____ Zip _____

Phone () _____

Phone () _____

Surgeon

Oncologist

Name: _____

Name: _____

Address: _____

Address: _____

City: _____ State _____ Zip _____

City: _____ State _____ Zip _____

Phone () _____

Phone () _____

I hereby authorize the UCSF Mount Zion Carol Franc Buck Breast Care Center to release all and any chart notes, laboratory and x-ray results, x-ray films, tissue slides and blocks concerning my illness and/or treatment to any physician or institution listed above as well as any and all physicians involved in my health care.

I also authorize and request that above physicians and/ or institutions to release to the UCSF Mount Zion Carol Franc Buck Breast Care Center all and any chart notes, laboratory and x-ray results, x-ray films, tissue slides and blocks concerning my illness and/or treatment to any physician or institution listed above as well as any and all physicians involved in my health care.

I will receive services with the understanding that in the event that my insurance coverage is not effective and/ or no authorization can be obtained, I will be responsible for all bills incurred in the Breast Care Center. I agree that I will be financially responsible for services rendered if I fail to obtain prior authorization as required by my health insurance plan. I will be responsible for paying all related fees incurred for any services received which are not a benefit stipulated in my coverage.

Patient Signature: _____ **Date:** _____