



TCCC Patient ID Form

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH (MM / DD / YYYY)	GENDER (circle one)
	<input type="radio"/> M <input type="radio"/> F

ADDRESS

STREET

APARTMENT/SUITE	CITY	STATE	ZIP

TELEPHONE

HOME	CELL	BUSINESS	EXT

EMAIL ADDRESS

ETHNICITY (check one)	RACE (check one)
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- Hispanic or Latino
- Not Hispanic or Latino

- White
- Black or African American
- Asian American
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Other Race

If other, please specify...

PHYSICIAN INFORMATION

ENDOCRINOLOGIST	
NAME	
OFFICE TELEPHONE	EXT
EMAIL ADDRESS	
STREET ADDRESS	

NUCLEAR MEDICINE SPECIALIST	
NAME	
OFFICE TELEPHONE	EXT
EMAIL ADDRESS	
STREET ADDRESS	

MEDICAL ONCOLOGIST	
NAME	
OFFICE TELEPHONE	EXT
EMAIL ADDRESS	
STREET ADDRESS	

RADIOLOGIST	
NAME	
OFFICE TELEPHONE	EXT
EMAIL ADDRESS	
STREET ADDRESS	

PRIMARY CARE PHYSICIAN	
NAME	
OFFICE TELEPHONE	EXT
EMAIL ADDRESS	
STREET ADDRESS	

SURGEON	
NAME	
OFFICE TELEPHONE	EXT
EMAIL ADDRESS	
STREET ADDRESS	

I, _____, hereby give my consent to the
PATIENT NAME
THANC Foundation to contact my physician(s) listed above to consider membership to participate in the TCCC.

Signature of Patient/Legal Representative

Date Signature of Patient/Legal Representative Relationship to the Patient



AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FROM BIMC/DR. MARK URKEN

PATIENT NAME		DATE OF BIRTH	
MEDICAL RECORD NO. (IF KNOWN)			

I authorize the following organization to release information as stated below from the patient health information record:

Information to be released FROM:

ORGANIZATION
Beth Israel Medical Center/Dr. Mark Urken
STREET ADDRESS, CITY, STATE, ZIP
10 Union Square East, Suite 5B, New York, NY 10003
PHONE/FAX
212-844-8775

Information to be released TO:

The THANC Foundation
10 Union Square East, Suite 5B
New York, NY 10003
Telephone: 212-844-6832
Fax: 212-844-8465

Information to be released:

All records for dates of service that include information related to treatment of my thyroid disease.
The purpose of this release is for research and data collection to improve collaborative cancer care.

Authorization for Release of Information

I understand that:

- ▶ Authorizing the disclosure of information is voluntary. I do not need to sign this form in order to assure treatment.
- ▶ I can cancel this authorization at any time by writing to the Health Information Services Department c/o THANC Foundation at 10 Union Square East, Suite 5B, New York, NY 10003. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- ▶ Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will not expire unless I send a written notice of cancellation.

Signature of Patient/Legal Representative

Date	Signature of Patient/Legal Representative	Relationship to the Patient



AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FROM HEALTHCARE PROVIDER

PATIENT NAME		DATE OF BIRTH	
MEDICAL RECORD NO. (IF KNOWN)			

I authorize the following organization to release information as stated below from the patient health information record:

Information to be released FROM:

ENDOCRINOLOGIST / THYROID CARE PROVIDER
STREET ADDRESS, CITY, STATE, ZIP
PHONE/FAX

Information to be released TO:

The THANC Foundation
10 Union Square East, Suite 5B
New York, NY 10003
Telephone: 212-844-6832
Fax: 212-844-8465

Information to be released:

All records for dates of service that include information related to treatment of my thyroid disease.
The purpose of this release is for research and data collection to improve collaborative cancer care.

Authorization for Release of Information

I understand that:

- ▶ Authorizing the disclosure of information is voluntary. I do not need to sign this form in order to assure treatment.
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- ▶ Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will not expire unless I send a written notice of cancellation.

Signature of Patient/Legal Representative

Date	Signature of Patient/Legal Representative	Relationship to the Patient
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THYROID
CANCER
CARE
COLLABORATIVE

Phillips Ambulatory Care Center
10 Union Square East, Suite 5B
New York, NY 10003
347-313-TCCC
347-313-8222

CONSENT FOR USE OF HEALTH INFORMATION IN THE THYROID CANCER CARE COLLABORATIVE

PATIENT NAME	DATE OF BIRTH		

I HEREBY give my consent to The THANC Foundation to use my healthcare information in the Thyroid Cancer Care Collaborative (TCCC).

I understand that my personal information will be de-identified and that The THANC Foundation is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and HITECH Act of 2009 covering Privacy and Security of my information.

Attached to this form is a full description of TCCC and why we are asking you to participate. The description tells you about **the reason for TCCC and any risks and benefits to you.**

If you have questions concerning TCCC, you may telephone: **(347) 313-8222.**

I, _____, clearly and fully understand the nature, requirements, risks and benefits of TCCC and consent that my information will be used for the sharing of my healthcare information between my participating healthcare providers and that it also may be used for data collection and research purposes.

Signature of Patient/Legal Representative

Date	Signature of Patient/Legal Representative	Relationship to the Patient
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I hereby release the THANC Foundation and its affiliates, successors and assigns and their respective employees, trustees and agents from and against any and all liability including reasonable attorneys fees arising out of the exercise of the rights granted by this consent.

Date	Signature of Patient/Legal Representative	Relationship to the Patient
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