



CEDARS-SINAI MEDICAL CENTER

Thank you for your interest in the GenRISK Adult Genetics Program at Cedars-Sinai Medical Center. Please take the time to read this letter, as it contains important information to help you get ready for the appointment and explains how our clinic works. At your visit you will meet with a genetic counselor and/or geneticist.

Enclosed please find the following:

- Directions to our facility
- Registration form
- Personal and Family History Questionnaire

Please complete the Registration form and both Personal and Family History Questionnaires and return to us **PRIOR** to your appointment. This information will enable us to provide you with appropriate and timely care. If information is missing or not completed, you may have to return for another appointment.

In addition, please read and note the following:

- If you have been diagnosed with cancer, we will require your pathology reports be faxed to us (310-423-9946) prior to your appointment.
- Not everyone is an appropriate candidate for genetic testing. Each individual will receive a personalized assessment at the time of their appt.
- Genetic testing costs are not included in the clinic visit. The majority of genetic tests are ordered via labs outside of our institution, and the price varies depending on the test. Most major insurance companies cover genetic testing when medically indicated, and will be reviewed in detail at your appointment.
- If you do have genetic testing, a second follow-up appointment is mandatory for genetic test results disclosure, interpretation and recommendations for follow-up care. We **DO NOT** disclose results over the phone; this is hospital policy.

If you have an HMO plan:

- It is your responsibility to obtain pre-authorization for the visit **PRIOR** to you appointment.
- Genetic testing requires a separate pre-authorization, and thus if your initial pre-authorization included the clinic visit, but not genetic testing, another visit will be required for blood draw and genetic testing.
- A follow up visit will also be required if genetic testing is performed, for results disclosure, and follow-up care recommendations; a preauthorization will also be required for that clinic visit.

We would like to thank you for choosing our program. If you have any questions, please visit our website at www.csmc.edu/951.html You will find a wealth of information about our program, as well as answers to the most frequently asked questions, such as genetic discrimination, etc.

The GenRISK Adult Genetics Staff
Medical Genetics Institute
Cedars-Sinai Medical Center
Phone 310-423-9913; fax 310-423-9946

8700 Beverly Blvd. ■ Los Angeles, CA 90048
Office (310) 423-3277 ■ www.cedars-sinai.edu

MEDICAL GENETICS - ADULTS

Date:	Expected DOS:
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PATIENT INFORMATION:

Name:	DOB:	Sex:	MRN:
Address:		City, State, Zip Code:	
Mother's Maiden Name:		Race:	Birthplace:
Home #:	Social Security No:		Religion:
Marital Status:			

EMERGENCY CONTACT:

Name:	Address:	Phone Number
Employer:	Occupation:	DOB:
Employ Phone:	Employ. Address:	
Name:	Address	Phone Number
Employer:	Occupation:	DOB:
Employ Phone:	Employ. Address:	

PRIMARY CARE PHYSICIAN INFORMATION:

Physician:	Contact:
Address:	City, State:
Phone:	Fax:

REFERRING PHYSICIAN INFORMATION [If Different from Primary Care Physician]:

Physician:	Contact:
Address:	City, State, Zip:
Phone:	Fax:

INSURANCE INFORMATION: (circle one) PPO HMO POS EPO

Insurance Name:		Phone # Medical Group Phone#	
Address:		City, State, Zip:	
Subscriber:	ID #:	Group #:	
Plan#:	Effective:		Co-Pay: \$
Diagnosis:		Medications:	
COMMENTS/NOTES			

DIRECTIONS TO GENRISK ADULT GENETICS PROGRAM AT CEDARS-SINAI MEDICAL CENTER:

Phone # 310.423.9913

405 SOUTH FROM WEST VALLEY:

405 South – Exit Santa Monica Boulevard
Left onto Santa Monica Boulevard (Travel 4 miles)
Right onto San Vicente Boulevard
Right on Gracie Allen Drive (Note: Gracie Allen Drive turns into Alden Drive)
Right onto George Burns Road for 1/2 block; then Left into Entrance of Parking Lot 2

FROM SOUTH BAY AND ORANGE COUNTY:

405 North – to 110 Harbor Freeway North – to 10 West
Exit Robertson Boulevard
Right onto Robertson Boulevard (Travel 3 miles)
Right onto Alden Drive
Left onto George Burns Road for 1/2 block; then Left into Entrance of Parking Lot 2

FROM THE EASY VALLEY:

Take Laurel Canyon Boulevard South
Laurel Canyon turns into Crescent Heights Boulevard
Right onto Beverly Boulevard
Left on George Burns Road
Right into Parking Lot 2

FROM 5 NORTH, 710 NORTH AND SOUTH, 60 WEST, 110 NORTH AND SOUTH:

To 10 Santa Monica Freeway West
Exit Robertson Boulevard
Right on Robertson Boulevard (Travel 3 miles)
Right on Alden Drive
Left on George Burns Road for 1/2 block; then Left into Entrance of Parking Lot 2

PARKING:

Parking is available in

- Steven Spielberg Building** (Parking Lot 2) on George Burns Road (Between Beverly Boulevard and Alden Drive)
- South Tower** on Gracie Allen Drive
- North Tower** on George Burns Road (Between Beverly Boulevard and Gracie Allen Drive)

All of these lots can be validated for \$3.50

Parking is also available in the Beverly Center for only \$1.00 for three hours

GENRISK ADULT GENETICS PROGRAM:

Our office is located in the Steven Spielberg Building on the corner of Alden Drive and George Burns Road.

Enter the building through the Ambulatory Care Center's entrance.

- Take the elevator to the second floor and make a right
- Make another quick right into the hallway
- At the end of the hallway, make a left turn
- Room 298 will be on your right side at the end of the hall



CEDARS-SINAI MEDICAL CENTER.
DEPARTMENT OF MEDICAL GENETICS
GENRISK ADULT GENETICS
HEALTH HISTORY

PATIENT I.D. _____

FAMILY HISTORY

Mother country of origin: _____ Father country of origin: _____

Are you of Hispanic Decent: Yes No Are you of Ashkenazi Jewish Decent: Yes No

Relation	Cancer Type	Major Medical Condition (Diabetes, Neurologic, Heart disease)	Age at Diagnosis	Current Age/Age at Death
Patient				
Spouse				
Patient's Children				
Patient's Siblings				
Patient's Parents				
Maternal Grandparents				
Maternal Aunts / Uncles				
Maternal Cousins				
Paternal Grandparents				
Paternal Aunts / Uncles				
Paternal Cousins				
Other (please indicate maternal or paternal & specify relationship)				

Name: _____ Date of Birth _____



CEDARS-SINAI MEDICAL CENTER

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ MRN: _____

Date of Birth _____

Persons/Organizations authorized to use or disclose the information: 1 _____

Persons/Organizations authorized to receive the information (must include name, address, phone number, fax number): _____

This Authorization applies to the following information (select only one of the following): 2

A. All health information pertaining to any medical history, mental or physical condition and treatment received.

[Optional] Except: _____

Only the following records or types of health information (including any dates): _____

B. I specifically authorize release of the following information (check as appropriate): 2,3

Mental Health treatment information

HIV test results

Alcohol / Drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

PURPOSE

Purpose of requested use or disclosure: 4 Patient request; OR Other: _____

EXPIRATION

This Authorization expires (not to exceed 24 months): 5 _____

(Insert Date or Event)

NOTICE OF RIGHTS AND OTHER INFORMATION

- I may refuse to sign this Authorization.
- I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: _____
- My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.
- I have a right to receive a copy of this authorization. 6
- Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. 7
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless

unless such disclosure is specifically required or permitted by law.

- I may inspect or obtain a copy of the health information that I am being asked to use or disclose. If this box is checked, the Requestor will receive compensation for the use or disclosure of my information.

SIGNATURE

Date: _____ Time: _____ a.m./p.m.

Signature: _____

(Patient / Representative / Spouse / Financially Responsible Party)

If signed by someone other than the patient, state your legal relationship to the patient: ⁸ _____

Witness: _____

Hospital Representative Processing Request: _____ Date: _____

(Signature)

- ¹ If the Authorization is being requested by the entity holding the information, this entity is the Requestor.
- ² This form may **not** be used to release both psychotherapy notes and other types of health information (see 45 CFR“164.508 (b)(3)(ii)). If this form is being used to authorize the release of psychiatric health information, a separate form must be used to authorize release of any other health information. An authorization for use or disclosure of HIV test results must **specifically** state that it authorizes the use or disclosure of HIV test results and must be signed by a witness.
- ³ If mental health information covered by Lanterman-Petris-Short Act is requested to be released to a third party by the patient, the physician, licensed psychologist, social worker with a master's degree in social work or marriage and family therapist, who is in charge of the patient must approve the release. If the release is not approved, the reasons there-fore should be documented. The patient could most likely legally obtain a copy of the record himself or herself and then provide the records to the third party.
- ⁴ The statement “at the request of the individual” is a sufficient description of the purpose when the individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- ⁵ If authorization is for the use or disclosure of protected health information for research, including the creation and main-tenance of a research database or repository, the statement “end of research study”, “None”, or similar language is suf-ficient.
- ⁶ Under HIPAA, the individual must be provided with a copy of the authorization when it has been requested by a cov-ered entity for its own uses and disclosures (see 45 CFR“164.508 (d)(1), (e) (2)).
- ⁷ If any of the exceptions to this statement, as recognized by HIPAA apply, then this statement must be changed to describe the consequences to the individual of a refusal to sign the authorization when that covered entity can condi-tion treatment, health plan enrollment, or benefit eligibility on the failure to obtain such authorization. A covered entity is permitted to condition treatment, health plan enrollment or benefit eligibility on the provision of an authorization as fol-lows: (i) to conduct research-related treatment, (ii) to obtain information in connection with a health plan's eligibility or enrollment determinations relating to the individual or for its underwriting or risk rating determinations. Under no circum-stances, however, may an individual be required to authorize the disclosure of psychotherapy notes.
- ⁸ The requestor is to complete this section of the form.

Reference: Welfare and Institutions Code Section 5328.7