NYOH New York Oncology Hematology
www.newyorkoncology.com

Patient Name

Medical Record No.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize New York Oncology Hematology (NYOH) to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. insurance company)
- The day to day healthcare operations of NYOH practice

I have also been informed of and given the right to review and secure a copy of NYOH Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the term of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. NYOH is required to agree to a request that we restrict a disclosure made to a health plan for payment or health care operations purposes, that is not otherwise required by law, if you, or someone other than the health plan on your behalf, paid for the services or item in question out-of-pocket.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with these restrictions.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____

Patient or guardian Signature Date

Permission to Share Medical Information

The following information may be **verbally** communicated to:

_____ _____

Name/Phone Number Relationship

_____ _____

Name/Phone Number Relationship

(This document does **not** permit release of any written health information)

All Medical Information Y / N

Include Mental Health Information Y / N

Include HIV/Aids STD Information Y / N

Permission to Leave a detailed Message at the following phone number or e-mail address:

Phone Number_____ and/or e-mail _____

_____ _____

Patient or guardian Signature Date

[ ] I DECLINE: Please do not discuss my care with anyone other than as allowed by HIPAA. Please do not leave me any detailed messages