NYOH New York Oncology Hematology
www.newyorkoncology.com

General Consent for Physician Services

I, or my authorized representative, hereby authorize and give my consent to the physicians and staff of New York Oncology Hematology, P.C. (NYOH) to perform such examinations, therapies, treatments, tests or procedures as in their judgment are considered necessary and advisable for my diagnosis, treatment and care. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me as to the results or effects of any examinations, therapies, treatments, tests or procedures.

RELEASE OF MEDICAL INFORMATION

I, or my authorized representative, consent to the exchange and disclosure of my medical information, including genetic testing and HIV/AIDS-related information, to other healthcare providers rendering care or treatment to me.

I, or my authorized representative, consent to the exchange and disclosure of all information, including genetic testing and HIV/AIDS-related information, needed to substantiate payment for medical care I received from NYOH to government agencies, insurance carriers or others who are financially liable for my medical care.

I, or my authorized representative, consent to the disclosure of my medical information, including genetic testing and HIV/AIDS-related information, to a federal, state, county or local health officer when mandated by law, including the New York State Cancer Registry for purposes of complying with New York State Public Health Law Section 2401.

X _____ _____ _____
Signature Patient / Legal Representative * | Print Name | Account Number

_____ _____ _____
Relationship to Patient | Date | Patient's Name (if someone else signs)*

_____ _____ _____
Witness | Print Name | Date

_____ _____ _____
Interpreter (if required) | Print Name | Date

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incompetent to sign.