Central Coast Oncology and Hematology

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Privacy Acknowledgment and General Consent

I understand that my privacy is protected and I have reviewed a copy of the Notice of Privacy Practices.	Please circle: Yes No
I consent to receive medical care and treatment from Central Coast Oncology & Hematology.	Yes No
I have read and understand the Office and Financial Policies. I understand that any violation of these terms is subject to referral to a collection agency and/or dismissal.	Yes No
I give my physician and/or physician representative permission to leave a confidential message including medical information by phone.	Yes No
If yes, please write phone number (s) _____ _____	
I give my physician and/or physician representative permission to discuss my medical care with the following person (s): _____ _____ Name/Relationship to the patient Name/Relationship to the patient	

I understand that under the Health Insurance Portability & Accountability Act of 1996 "HIPPA", I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amount the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. This release of information will remain in effect until terminated by me in writing.

_____ _____
Patient Name Printed Date

_____ _____
Signature of Patient/Guardian Patient Date of Birth

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