DOTHAN
Hematology + Oncology

HIPAA AUTHORIZATION

It is the policy of this office to maintain strict confidentiality concerning the care and/or treatment received here. However, there are times and circumstances in which you may wish for us to speak with someone else about these matters. Do we have the permission to:

Leave a message on your answering machine?	___ Yes ___ No
Call you at work?	___ Yes ___ No
Leave a message at your place of employment?	___ Yes ___ No
Discuss your medical condition with your emergency contact?	___ Yes ___ No
Discuss your medical condition with any other family member or friend?	___ Yes ___ No

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Federal regulations allow us to disclose protected health information from your record in order to provide treatment to you, to obtain payment for the services we provided and for other professional activities known as "healthcare operation" (for example, sending your medical records to other physicians).

This consent is voluntary; you may refuse to sign it. However we are permitted to refuse to provide healthcare services if this consent is not granted or if the consent is later revoked.

I hereby consent to the use or disclosure of my protected health information as specified above.

_____ _____
Print Name Date of Birth

_____ _____
Signature of Patient/Guardian Date

Privacy Notice Acknowledgement

I, the undersigned, acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient/Guardian Date