NYOH New York Oncology Hematology

Notice of Privacy Practices Acknowledgment

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

Signature Patient / Legal Representative*	**Print Legal Name**	**Date**
Relationship to Patient	**Patient's Name (if someone else signs)***	

Permission to Share Medical Information

☐ **I give my permission for New York Oncology Hematology to share the information indicated below to the person(s) I have specified.**
☐ **I decline to have my care discussed with anyone other than as allowed by HIPAA.**

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

Name and Phone #	Relationship
Name and Phone #	Relationship

Information Authorized to Communicate

All Medical Information	Mental Health Information	HIV/AIDS or STD Information
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medical Record No. _____