NYOH New York Oncology Hematology

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 have received a copy of the **Notice of Privacy Practices** from New York Oncology Hematology (NYOH), which contains a more comprehensive description of the uses and disclosures of my protected health information, as well as my rights under HIPAA.

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.

I understand and allow NYOH to release my personal information to Patient Assistance Foundations or Copay Assistance Programs. I grant permission to NYOH to act on my behalf to apply for any and all financial assistance programs necessary to help with my financial needs. I agree to provide proof of income upon request by NYOH or any other foundation or assistance program.

I understand that all foundation or copay assistance is subject to the availability of funds at the time the request is made and that this does not guarantee payment.

Enrollment in a foundation or drug assistance program does not guarantee that assistance will be obtained. Assistance is subject to approval in accordance with the program guidelines. The programs also reserve the right to change or terminate the program without prior notice. In the event that a drug or service date is not covered by program assistance, the patient will be fully responsible for the cost.

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.

I understand that this information is confidential unless specifically released by me, the patient.

Communication Consent – New York Oncology Hematology (NYOH)

I authorize New York Oncology Hematology (NYOH) to use any email address or telephone number I provide—including those provided for family members or designated representatives—for communications related to my healthcare and financial responsibilities. This includes both mobile and landline numbers, as well as any numbers or email addresses that may be forwarded or transferred from other sources.

These communications may include, but are not limited to:

- Appointment reminders and scheduling updates
- Pre- and post-visit instructions (e.g., surgical, dietary, medication-related)
- Follow-up care and treatment planning
- Referrals, prescription information, or coverage details
- Information about my condition, diagnosis, or treatment options
- Invitations to participate in surveys or provide feedback
- Information about available programs, services, or educational materials
- Instructions for accessing records or portal accounts
- Financial communications such as payment reminders, billing updates, financial assistance screenings, and other billing-related notices

I consent to NYOH, its staff, and authorized agents (including billing or collections personnel) contacting me via phone, text, or email. This may include the use of automated dialing systems, pre-recorded or artificial voice messages, or messages sent over recorded lines.

If I am not the patient, I confirm that I am authorized to receive communications on the patient's behalf and am involved in their care and/or financial responsibilities.

I understand that email and text messaging are not encrypted, and there is a risk that information could be accessed by unintended third parties or stored by service providers. These messages may include identifiable details such as my name, appointment information, provider details, or billing account numbers. Message and data rates may apply for text messages.

Additional terms may be posted on the NYOH website and may be updated over time. I understand I can opt out of specific types of messages by notifying NYOH in writing. However, I may continue to receive other types of communication unless I opt out of each separately.

Signature Patient / Legal Representative*	**Print Name**	**Date**
Relationship to Patient	**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.*

Account Number _____