Hematology and Oncology Associates of Northeastern PA, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgment and Consent

This consent authorizes Hematology and Oncology Associates of Northeastern PA to use or disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Hematology and Oncology Associates of Northeastern PA has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Revisions to Notice of Privacy Practices. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. Copies of revised notices will be available at the reception desk or by submitting a written request to our privacy officer.

How to contact our privacy officer

Mail: Hematology and Oncology Associates of Northeastern PA
Attention: Privacy Officer
Address: 1100 Meade Street Dunmore, PA 18512
Telephone: 570-342-3675
Fax: 570-342-3316

Acknowledgment and Consent

Print or type all information except the signature.

I have received the Notice of Privacy Practices for Hematology and Oncology Associates of Northeastern PA. Hematology and Oncology Associates of Northeastern PA is authorized to use and disclose health information about _____
(patient name) for treatment, payment, and health care operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of patient or personal representative Date

Personal representative information (if applicable): _____
Medical Record #

_____
Name of personal representative

_____
Relationship to patient (or other authority)

HEMATOLOGY & ONCOLOGY ASSOCIATES OF NORTHEASTERN PA. PC

1100 MEADE STREET
DUNMORE, PA 18512

Tel (570) 342-3675
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In addition, I authorize use and disclosure of my health information to the following:

Contact 1: EMERGENCY CONTACT

Name:_____
Address:_____
Relationship:_____
Phone:_____
Additional Phone Numbers:_____
Cell Phone Number:_____

Contact 2

Name:_____
Address:_____
Relationship:_____
Phone:_____
Additional Phone Numbers:_____
Cell Phone Number:_____

Contact 3

Name:_____
Address:_____
Relationship:_____
Phone:_____
Additional Phone Numbers:_____
Cell Phone Number:_____

_____ _____
Signature of Patient Medical Record Number

_____
Date

*If you have additional contacts, please ask the receptionist for another form