Northwest Oncology, PC

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

- Conduct, plan and direct my treatment and follow-up among 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 have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name: ______________________________ Signature: ______________________________

I hereby authorize the delegated parties below to request and receive the release of my protected health information regarding my treatment, payment or administrative operations related to my treatment and payment. I understand that the identity of designated parties must be verified before the release of any of my information.

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office or notifying a member of the staff.
- Information used or disclosed pursuant to the authorization may be subject to re-discloser by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization, and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment.

Patient Name: ______________________________

Signature: ______________________________