medical oncology associates

CONFIRMATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ DOB: _____

To protect your privacy, please let us know how you would like us to contact you and who we may release your private health information (PHI) to on your behalf.

☐ **NO** – please do not discuss PHI with anyone. **WARNING: if you choose this option and you become ill and unable to call or come into the office for assistance we may, in our professional judgment, disclose necessary PHI to another medical professional to ensure you are given appropriate medical care.**

☐ **YES** – I authorize the physicians and staff at Medical Oncology Associates to communicate with:

Name	Relationship to Patient	Home Phone	Cell Phone

What kind of PHI may we discuss with your designated family members and/or others involved with your care?

☐ Medical Care Information ☐ Billing and Payment Information

May we contact you at:

Home? ☐ Yes ☐ No Phone # _____ Work? ☐ Yes ☐ No Phone # _____

Cell? ☐ Yes ☐ No Phone # _____

Via Email? ☐ Yes ☐ No Email Address _____

Via Mail? ☐ Yes ☐ No Address _____

May we leave a message on your answering machine or cell? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

May we leave a message with a family member or other person at your home? ☐ Yes ☐ No

Any information? ☐ Yes ☐ No

Limit information to the following: _____

I _____, understand the above authorization will remain in effect until I change it in writing. I have been given a copy of the Notice of Privacy Practices for Medical Oncology Associates.

Patient Signature _____ **Date** _____