REGIONAL
MEDICAL ONCOLOGY CENTER

HIPAA CONSENT

TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I _____understand that as part of my healthcare, Regional Medical Oncology Center originates and maintains paper and / or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that Regional Medical Oncology Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that Regional Medical Oncology Center reserves the right to change their notice and practices and prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations. Should Regional Medical Oncology Center change their notice, they will send me a copy of any revised notice to the address I've provided (whether US Mail or if I agree Email).

☐ *Please do not mail my clinical summary by US Mail. I will obtain this information from the patient portal.*
☐ *Please allow the following individuals access to my health information via the patient portal.*

I wish to allow the following individuals access to my Health Information:

Name: _____Relationship_____Contact #_____

Name: _____Relationship_____Contact #_____

Name: _____Relationship_____Contact #_____

Name: _____Relationship_____Contact #_____

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for there permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____ _____

Patient Signature **Date**

Patient Chart ID: _____ Patient Date of Birth:_____