
Central Coast Oncology & Hematology
Amy McMullen, MD Michael Yen, MD PhD

Privacy Acknowledgment and General Consent

I understand that my privacy is protected and I have reviewed a copy of the Notice of Privacy Practices.	Please circle: Yes No
I consent to receive medical care and treatment from Central Coast Oncology & Hematology.	Yes No
I have read and understand the Office and Financial Policies. I understand that any violation of these terms is subject to referral to a collection agency and/or dismissal.	Yes No
I give my physician and/or physician representative permission to leave a confidential message including medical information by phone.	Yes No
If yes, please write phone number(s) _____	
I give my physician and/or physician representative permission to discuss my medical care with the following person(s): _____	
Name/Relationship to the patient	Name/Relationship to the patient
Please circle: I want the primary contact for communication from my doctor to be <u>myself</u> or <u>other</u> : _____	

I understand that under the Health Insurance Portability & Accountability Act of 1996 "HIPPA", I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up with 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 understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. This release of information will remain in effect until terminated by me in writing or one year from the date of my signature, whichever date comes first.

<hr/> Patient Name Printed	<hr/> Patient Date of Birth
<hr/> Signature of Patient/Guardian	<hr/> Today's date