CARO | CENTRAL ALABAMA RADIATION ONCOLOGY

HIPAA PRIVACY FORM

Patient Name:	Date of Birth:	Social Security #:

By signing this form, I hereby acknowledge receipt of the "Notice of Privacy Practices".

I understand it is the policy of this healthcare facility to protect the privacy of my healthcare information.

As a necessary condition of treatment, I consent to release of my protected health information to other physicians and third party payers for the purpose of my treatment, payment for my treatment, and general operation of the healthcare facility. Otherwise, healthcare staff will only disclose information about me with my permission.

If I expect a family member to telephone or pick up test results or films on my behalf, healthcare staff will only disclose information to persons designated by me. Similarly, if I expect a family member or friend to routinely be involved in my healthcare and I would like the healthcare staff to be able to share that information with him or her, I need to list their name below.

Persons Permitted by Patient to Receive Patient's Healthcare Information if you don't want to give permission please write NONE.

Date	Name of Person	Release all information or specify	Relationship to the Patient	Telephone #	Your Initials
				( )	
				( )	
				( )	
				( )	

_____ _____

Patient Signature Date