Consent to Use and Disclose Health Information for Treatment, Payment or Healthcare Operations
Notice of Privacy Practices Acknowledgement

Patient Name: _____**Date of Birth:** _____

I understand that as part of my healthcare, The START Center for Cancer Care, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that The START Center for Cancer Care, its agents, employees, and contractors may use and disclose my health care information for these and other treatment, payment, and health care operation reasons.

As a part of treatment, payment, and health care operations, The START Center for Cancer Care may disclose medical information to be used by the following individual or organization.

_____

(Name and Address of Physicians or Clinic)

_____

(Name and Address of Family and Friends)

_____

(Name and Address of Family and Friends)

I understand and have been provided access to the ***NOTICE OF INFORMATION PRACTICES*** that provides a more complete description of information uses and disclosures.

_____ _____ _____

Signature of Patient or Legal Representative *Date* *Relationship to Patient*

Reason for Patient Refusal to Sign:

_____

_____ _____

Employee Signature Date

Effective 01012016