START CENTER FOR CANCER CARE
A Partner of OneOncology

Consent and Notice of Privacy Practices Acknowledgment

FRM-REG-NPP-001 Rev. 2.0

Please print clearly in blue or black ink, or complete this form on screen.

SECTION A. PATIENT IDENTIFICATION

Patient Last Name	First Name	Middle Initial	Date of Birth (DD/MM/YYYY)

SECTION B. CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Records We Maintain. I understand that as part of my care, 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.

2. Consent for Treatment, Payment and Health Care Operations. I consent to the use and disclosure of my protected health information by START Center for Cancer Care and by its physicians, employees, agents, and contractors for treatment, payment, and health care operations, as those terms are defined at 45 CFR 164.501.

3. What This Consent Does Not Cover. This consent does not permit disclosures that require my separate written authorization under 45 CFR 164.508, including most disclosures to my employer, disclosures for marketing, and any sale of my information. Under Texas Health and Safety Code Section 181.154, START will obtain my separate authorization before electronically disclosing my protected health information for any purpose other than treatment, payment, health care operations, or as otherwise required by law.

4. My Right to Request Restrictions. I may ask START to restrict how my information is used or disclosed. START is not required to agree to every request. START must agree to restrict disclosure to my health plan when the disclosure is for payment or health care operations, is not otherwise required by law, and I have paid for the item or service in full out of pocket (45 CFR 164.522(a)(1)(vi)).

5. My Right to Revoke. I may revoke this consent at any time by written notice to the START Center for Cancer Care Privacy Officer. Revoking this consent will not affect any use or disclosure that START already made while relying on it.

SECTION C. PERSONS AND ORGANIZATIONS START MAY SHARE MY INFORMATION WITH

Complete this section only if you want START to be able to share your information with someone involved in your care, as permitted by 45 CFR 164.510(b). Leaving it blank does not limit disclosures for treatment, payment, or health care operations. This list replaces any list you have given START before. You may add, change, or remove a name at any time by notifying the Privacy Officer in writing.

Physician or Clinic - Name	Address or City	Phone or Fax

Person 1 - Name	Relationship to Patient	Phone	Information They May Receive
			Select

Person 2 - Name	Relationship to Patient	Phone	Information They May Receive
			Select

Person 3 - Name	Relationship to Patient	Phone	Information They May Receive
			Select

SECTION D. NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been offered a copy of the START Center for Cancer Care Notice of Privacy Practices, which describes more fully how START may use and disclose my protected health information and what rights I have regarding that information. I understand that START may revise the Notice, and that the current version is posted at each START location and is available on request.

How the Notice was provided	Notice version or effective date (DD/MM/YYYY)	Language in which the Notice was provided
Select		Select

Was an interpreter or translated Notice used?	Interpreter name or service, if used
Select	

SECTION E. SIGNATURE

Signature of Patient or Legal Representative	Printed Name	Date (DD/MM/YYYY)
Wet signature, or START-approved electronic signature		

Relationship to Patient (if not signed by the patient)	If signed by a personal representative, describe the legal authority to act for the patient

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SECTION F. IF THE PATIENT DOES NOT SIGN (completed by START staff)

45 CFR 164.520(c)(2)(ii) requires START to document its good faith effort to obtain this acknowledgment and the reason the acknowledgment was not obtained. Complete this section only when Section E is left unsigned. Care is not withheld because a patient declines to sign.

Reason the acknowledgment was not obtained	Was a copy of the Notice still provided to the patient?
Select	Select

Additional detail describing the good faith effort made

Employee Signature	Printed Name and Title	Date (DD/MM/YYYY)
Wet signature, or START-approved electronic signature		