PATIENT HIPAA CONSENT FORM / NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations Virginia Oncology Associates such as quality assessments and treatment authorizations;
- A family member or friend who is involved in my medical care or who helps me pay for my care (unless otherwise requested not to).
- We may also share information through Carequality, a healthcare exchange, which is a provider portal for other providers involved in your care to have all the information necessary to diagnose and treat you

PLEASE RELEASE AND DISCUSS MY HEALTH INFORMATION TO THE FOLLOWING INDIVIDUAL(S):

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INITIALS	I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

NAME OF PATIENT (PRINTED):

LAST NAME, FIRST NAME, MIDDLE INITIAL _____ **DATE OF BIRTH**

NAME OF PERSONAL REPRESENTATIVE (PRINTED) _____ **RELATIONSHIP TO PATIENT**

PATIENTS (PERSONAL REPRESENTATIVE) SIGNATURE _____ **DATE**