

Peachtree Hematology-Oncology Consultants, P.C.

Patient Acknowledgement / Consent Form

I hereby give my consent for Peachtree Hematology – Oncology Consultants, P.C. to use and disclose protected health information (“PHI”) about me to carry out treatment, payment and healthcare operations (TPO). (Peachtree Hematology-Oncology Consultants, P.C.’s Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent (a copy is in the reception area and a copy may be requested from the receptionist). Peachtree Hematology-Oncology Consultants, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Peachtree Hematology-Oncology Consultants, P.C., Privacy Officer at 1800 Howell Mill Road, NW, Suite 800, Atlanta, Georgia 30318.

With this consent, Peachtree Hematology–Oncology Consultants, P.C. may call my home or mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminders, insurance items or patient statements, as well as any calls, or printed information pertaining to my clinical care, including laboratory results among others.

I have the right to request that Peachtree Hematology-Oncology Consultants, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound to this agreement.

By signing this form, I am consenting to Peachtree Hematology–Oncology Consultants, P.C.’s use and disclosure of my PHI to carry out TPO. I hereby release Peachtree Hematology–Oncology Consultants, P.C. and its agents and employees from any and all liabilities, damages, losses, claims and expenses which may arise from the release of the information authorized above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Peachtree Hematology–Oncology Consultants, P.C. may decline to provide treatment to me. A photocopy of this document shall be as valid as the original.

Signature of Patient or Legal Guardian

Relationship to Patient

Date of Birth

Print Patient’s Name or Legal Guardian

Date

Peachtree Hematology-Oncology Consultants, P.C.

Consent for Disclosure to Family Member and/or Personal Representative

PATIENT NAME/ID # _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for the Practice and Dr. _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Conditions for Disclosure (Check the item(s) that apply):

The Practice may disclose my personal health information to the individual(s) above **only** in my presence.

The Practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or regular mail.

Other Conditions of Disclosure:

I understand that this consent may be revoked by me at any time by written notice to the Practice.

Patient Signature: _____

Date of Signature: _____

Witnessed by: _____ Title/Position: _____

Print Name of Witness: _____ Date: _____