Medical Oncology Care ASSOCIATES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ('HIPAA), I have certain rights to privacy regarding my protected health information (PHI).

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may obtain a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my heath information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Patient Signature _____ Date _____

MEDICAL ONCOLOGY CARE ASSOCIATES OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials	Reason
_____	_____	_____

1010 West La Veta Avenue,, Suite 250, Orange, CA 92808,
Tel: 714.541.6622 , Fax: 714.541.0531, Billing Dept: 714.541.1406