HIPAA PRIVACY AUTHORIZATION FORM

(Health Insurance Portability & Accountability Act)

1. I authorize my physician and/or administrative and clinical staff to use my protected health information and disclose the following protected health information to:
   ❑ Any/All Family Members ❑ Name of Person(s) : ______________________________
2. The protected health information to be used or disclosed is:
   ❑ All Medical Records ❑ Specific Records as listed below:
   (Describe the information to be used/disclosed-for example: types of services, any or all laboratory reports, pathology, x-ray reports, progress notes, or "all medical records").
   ____
   ____
3. This protected health information is being used or disclosed for the following purposes:
   ❑ At the request of the individual (the patient) or ❑ List below the specific purpose for the use or disclosure.
   ____
   ____
4. This authorization shall be in force and effect until at which time this authorization to use or disclose this protected health information is recinded in writing by patient.
5. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Medical Oncology Care Associates at 1010 W. La Veta Avenue, Suite 250, Orange, CA 92868.**
   I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. 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.
7. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
8. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative ______________________________ Date ______________

PRINT NAME of Patient or Personal Representative ______________________________ Relationship to patient ______________

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