HIGHLANDS
ONCOLOGY GROUP

ONCO #

NOTICE OF PRIVACY PRACTICES
and
RIGHT TO ACCESS Form

Your signature below acknowledges that you have received a copy of the notice of PRIVACY PRACTICES and the AREA PHARMACIES & SCAN LIST:

Patient Name_____
please print

_____
please sign

_____
Date Signed

Patient Representative (if applicable):_____
please print

Relationship of Representative:_____
please print

RIGHT TO ACCESS

In order to protect your privacy, Highlands Oncology Group asks you to list family members, friends,or any person (s) who can access/request or inquire regarding your Protected Health Information (PHI),which includes medical,billing,and financial information. Please list these individuals in the space provided below: (Please Print)

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Patient's Signature_____Date_____

STAFF USE ONLY

We provided the Notice of Privacy Practices, Area Pharmacy & Scan Listing, along with the Right To Access Authorization. We have explained to the patient the importance of listing individuals who will have the right to access their health & billing information. If no one is listed, we will not be able to share any of the health or billing records.

_____
Employee Signature

_____
Date